H.R. 1818, THE FAMILY MEDICAL SAVINGS AND INVESTMENT ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JUNE 27, 1995

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SUBMISSIONS FOR THE RECORD

104TH CONGRESS
1ST SESSION

H. R. 1818

To amend the Internal Revenue Code of 1986 to allow a deduction for contributions to a medical savings account by any individual who is covered under a catastrophic coverage health plan.

IN THE HOUSE OF REPRESENTATIVES

JUNE 13, 1995

Mr. ARCHER (for himself, Mr. JACOBS, Mr. THOMAS, Mr. DELAY, Mr. CRANE, Mr. SHAW, Mr. BUNNING of Kentucky, Mr. HOUGHTON, Mr. HERGER, Mr. MCCRERY, Mr. HANCOCK, Mr. CAMP, Mr. RAMSTAD, Mr. ZIMMER, Mr. NUSSLE, Mr. SAM JOHNSON of Texas, Ms. DUNN of Washington, Mr. COLLINS of Georgia, Mr. PORTMAN, Mr. ENGLISH of Pennsylvania, Mr. ENSIGN, Mr. CHRISTENSEN, Mr. SOLOMON, Mr. YOUNG of Alaska, Mr. MYERS of Indiana, Mr. DORNAN, Mr. SMITH of Texas, Mr. ROHRABACHER, Mr. FROST, Mr. HALL of Texas, Mr. BURTON of Indiana, Mr. LIPINSKI, Mr. TORRICELLI, Mrs. VUCANOVICH, Mr. SAXTON, Mr. CALLAHAN, Mr. GALLEGLY, Mr. PICKETT, Mr. UPTON, Mr. POSHARD, Mr. STEARNS, Mr. BARTLETT of Maryland, Mr. BREWSTER, Mr. CRAPO, Mr. HILLEARY, Mr. INGLIS of South Carolina, Mr. KNOLLENBERG, Mr. MANZULLO, Mr. ROYCE, Mr. TALENT, Mr. CHAMBLISS, Mr. CHRYSLER, Mr. GANSKE, Mr. JONES, Mr. LARGENT, Mr. THORNBERRY, Mr. WATTS of Oklahoma, Mr. WELLER, Mr. WHITE, Mr. WICKER, Mr. HOKE, and Mrs. JOHNSON of Connecticut) introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend the Internal Revenue Code of 1986 to allow a deduction for contributions to a medical savings account by any individual who is covered under a catastrophic coverage health plan.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Family Medical Savings and Investment Act of 1995".

SEC. 2. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. MEDICAL SAVINGS ACCOUNTS.

"(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.

"(b) LIMITATIONS.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the lesser of—

"(A) $2,500, or

"(B) the deductible under the catastrophic health plan covering such individual.

If the catastrophic health plan covering such individual provides coverage for any other eligible individual who is the spouse or any dependent (as defined in section 152) of the taxpayer, subparagraph (A) shall be applied by substituting '$5,000' for '$2,500'.

"(2) PRORATION OF LIMITATION.—

"(A) IN GENERAL.—The limitation under paragraph (1) shall be the sum of the monthly limitations for months during the taxable year that the individual is an eligible individual if—

"(i) such individual is not an eligible individual for all months of the taxable year,

"(ii) the deductible under the catastrophic health plan covering such individual is not the same throughout such taxable year, or

"(iii) such limitation is determined using the last sentence of paragraph (1) for some but not all months during such taxable year.

"(B) MONTHLY LIMITATION.—The monthly limitation for any month shall be an amount equal to 1/12 of the limitation which would (but for this paragraph and paragraph (3)) be determined under paragraph (1) if the facts and circumstances as of the first day of such month that such individual is covered under a catastrophic health plan were true for the entire taxable year.

"(3) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS, INCLUDING TRANSFERS FROM FLEXIBLE SPENDING ARRANGEMENTS.—No deduction shall be allowed under this section for any amount paid for any taxable year to a medical savings account of an individual if—

"(A) any amount is paid to any medical savings account of such individual which is excludable from gross income under section 106(b) for such year, or

"(B) in a case described in paragraph (4)(B), any amount is paid to any medical savings account of either spouse which is so excludable for such year.

"(4) SPECIAL RULE FOR MARRIED INDIVIDUALS.—

"(A) IN GENERAL.—This subsection shall be applied separately for each married individual and without regard to any community property laws.

"(B) SPECIAL RULE.—If individuals who are married to each other are covered under the same catastrophic health plan, then the amounts applicable under subparagraphs (A) and (B) of paragraph (1) shall be divided equally between them unless they agree on a different division.

"(5) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(c) DEFINITIONS.—For purposes of this section—

"(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means, with respect to any month, any individual—

"(A) who is covered under a catastrophic health plan at any time during such month, and

"(B) who is not, while covered under a catastrophic health plan, covered under any health plan—

"(i) which is not a catastrophic health plan, and

"(ii) which provides coverage (other than permitted coverage) for any services which are covered under the catastrophic health plan.

"(2) CATASTROPHIC HEALTH PLAN.—The term 'catastrophic health plan' means any health plan which provides no compensation for an individual's expenses covered by the plan (other than for permitted coverage) for any calendar year to the extent such expenses for such calendar year do not exceed $1,800 ($3,600 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual) or such higher amounts as may be specified by the plan.

"(3) PERMITTED COVERAGE.—The term 'permitted coverage' means—

"(A) coverage only for accidents, dental care, vision care, disability income, or long-term care insurance,

"(B) Medicare supplemental health insurance,

"(C) coverage issued as a supplement to liability insurance,

"(D) liability insurance, including general liability insurance and automobile liability insurance,

"(E) worker's compensation or similar insurance,

"(F) automobile medical-payment insurance,

"(G) coverage for a specified disease or illness, and

"(H) a hospital or fixed indemnity policy.

"(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

"(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

"(A) Except in the case of a rollover contribution described in subsection (f)(3), no contribution will be accepted unless it is in cash.

"(B) The trustee is a bank (as defined in section 408(n)), an insurance (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

"(C) No part of the trust assets will be invested in life insurance contracts.

"(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(E) The interest of an individual in the balance in his account is nonforfeitable.

"(2) QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder—

"(i) for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any depend-

ent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise, or

"(ii) for long-term care insurance for such individual, spouse, or dependent.

"(B) HEALTH PLAN COVERAGE MAY NOT BE PURCHASED FROM ACCOUNT.—

"(i) IN GENERAL.—Such term shall not include any amount paid for coverage under a health plan unless such plan is a catastrophic health plan.

"(ii) EXCEPTION.—Clause (i) shall not apply to any amount paid for long-term care insurance.

"(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the medical savings account was established.

"(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

"(A) Section 219(d)(2) (relating to no deduction for rollovers).

"(B) Section 219(f)(3) (relating to time when contributions deemed made).

"(C) Except as provided in section 106(b), section 219(f)(5) (relating to employer payments).

"(D) Section 408(h) (relating to custodial accounts).

"(e) TAX TREATMENT OF ACCOUNTS.—

"(1) ACCOUNT TAXED AS GRANTOR TRUST.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the account holder of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

"(B) TREATMENT OF CAPITAL LOSSES.—With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall be allowed only to the extent of capital gains from such assets for such taxable year. Any capital loss which is disallowed under the preceding sentence shall be treated as a capital loss from the sale or exchange of such an asset in the next taxable year. For purposes of this

subparagraph, all medical savings accounts of the account holder shall be treated as 1 account.

"(2) ACCOUNT ASSETS TREATED AS DISTRIBUTED IN THE CASE OF PROHIBITED TRANSACTIONS OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

"(f) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder shall be included in the gross income of such holder to the extent such amount does not exceed the excess of—

"(i) the aggregate contributions to such account which were allowed as a deduction under this section or which were excluded under section 106(b), over

"(ii) the aggregate prior payments or distributions from such account which were includible in gross income under this paragraph.

"(B) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all medical savings accounts of the account holder shall be treated as 1 account,

"(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 10 percent of the amount of such payment or distribution

which is includible in gross income under paragraph (1).

"(B) DISABILITY OR DEATH CASES.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

"(3) ROLLOVERS.—Paragraph (1) shall not apply to any amount paid or distributed out of a medical savings account to the account holder if the entire amount received (including money and any other property) is paid into another medical savings account for the benefit of such holder not later than the 60th day after the day on which he received the payment or distribution.

"(4) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care to the extent of the amount of such payment or distribution which is excludable from gross income solely by reason of paragraph (1)(A).

"(g) COST-OF-LIVING ADJUSTMENT.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1996, each dollar amount in subsection (b)(1) or in subsection (c)(2) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the medical care cost adjustment for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(B) such component for August of 1995.

"(h) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and

in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations."

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (15) the following new paragraph:

"(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220."

(c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—The text of section 106 of such Code (relating to contributions by employer to accident and health plans) is amended to read as follows:

"(a) GENERAL RULE.—Gross income of an employee does not include employer-provided coverage under an accident or health plan.

"(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

"(1) IN GENERAL.—In the case of an employee who is an eligible individual, gross income does not include amounts contributed by such employee's employer to any medical savings account of such employee. For purposes of the preceding sentence, the

terms 'eligible individual' and 'medical savings account' have the respective meanings given to such terms by section 220.

"(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

"(3) TRANSFERS FROM FLEXIBLE SPENDING ARRANGEMENTS.—

"(A) IN GENERAL.—A flexible spending arrangement for health shall not cease to be treated as such an arrangement, and no amount shall be includible in the gross income of the employee, solely because amounts not paid out as reimbursements under such arrangement are contributed to a medical savings account of such employee.

"(B) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this paragraph, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

"(i) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

"(ii) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the cost of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

"(4) COORDINATION WITH DEDUCTION LIMITATION.—The amount excluded from the gross income of an employee under this subsection for any taxable year shall not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year."

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 of such Code is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting "; or", and by inserting after

paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking "or" at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting "; or", and by inserting after paragraph (18) the following new paragraph:

"(19) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) of the Internal Revenue Code of 1986."

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

"(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include

any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking "or" at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting "; or", and by inserting after paragraph (16) the following new paragraph:

"(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking "or" at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting "; or", and by inserting after paragraph (20) the following new paragraph:

"(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able

to exclude such payment from income under section 106(b)."

(d) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to tax on prohibited transactions) is amended—

(1) by adding at the end of subsection (c) the following new paragraph:

"(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account.", and

(2) by inserting "or a medical savings account described in section 220(d)" in subsection (e)(1) after "described in section 408(a)".

(e) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement accounts or annuities) is amended—

(1) by inserting "**OR ON MEDICAL SAVINGS ACCOUNTS**" after "**ANNUITIES**" in the heading of such section, and

(2) by adding at the end of subsection (a) the following: "The person required by section 220(h) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure to so file unless it is shown that such failure is due to reasonable cause."

(f) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

"Sec. 220. Medical savings accounts.
"Sec. 221. Cross reference."

(2) The table of sections for subchapter B of chapter 68 of such Code is amended by inserting "or on medical savings accounts" after "annuities" in the item relating to section 6693.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

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H.R. 1818, THE FAMILY MEDICAL SAVINGS AND INVESTMENT ACT

TUESDAY, JUNE 27, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 11 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
June 15, 1995
No. HL-12

CONTACT: (202) 225-3943

Thomas Announces Hearing On H.R. 1818, The "Family Medical Savings And Investment Act Of 1995"

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on H.R. 1818, the Family Medical Savings and Investment Act. **The hearing will take place on Tuesday, June 27, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 11:00 a.m.**

Oral testimony at this hearing will be heard from invited witnesses. Any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The fact that Americans with conventional health insurance have few incentives to buy medical services carefully or benefit from staying well are major factors affecting health care cost growth. One approach to providing incentives for Americans to be more cost conscious purchasers of medical services is to make available alternatives to conventional insurance such as medical savings accounts (MSAs). Medical savings accounts are used to pay for out-of-pocket medical expenses up to a catastrophic limit after which costs would be covered by insurance. MSAs would give people more control over their health care dollars and the opportunity to save the MSA funds not spent that year for future health care needs.

H.R. 1818, the Family Medical Savings and Investment Act of 1995, allows individuals who are covered by a catastrophic health plan to maintain a medical savings account to assist in saving for expenses not covered by the health plan. Within limits, contributions would be excludable from gross income if made by the employer and deductible if made by the individual. In general, the amount of the individual or employer contributions that could be deducted or excluded for a taxable year would be the lesser of (1) the deductible under the catastrophic health plan, or (2) $2,500 if the MSA covers only the individual or $5,000 if the MSA covers the individual and the spouse or a dependent of the individual. Withdrawals from an MSA would be excludable from income if used for medical expenses for the individual and his or her spouse or dependents.

In announcing the hearing, Chairman Thomas stated: "The American people know that health care spending must be reduced -- it takes an ever increasing bite out of the average family paycheck. What we are trying to do with this bill is provide people with a tool to help them take control of their own health care spending."

FOCUS OF THE HEARING:

The hearing will examine the issues involved in expanding health care coverage options available to individuals and families under H.R. 1818. The Subcommittee is particularly interested in technical issues involved in implementation of the MSAs established in H.R. 1818.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, July 18, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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Chairman THOMAS. The Health Subcommittee will come to order, please.

Today, the Health Subcommittee will receive testimony on H.R. 1818, the Family Medical Savings and Investment Act of 1995. I am pleased to be an original cosponsor of what I believe to be an important health reform and tax legislation bill. It has been developed by the Chairman of the Ways and Means Committee, Congressman Bill Archer, and our distinguished colleague from the Committee, Congressman Andy Jacobs.

H.R. 1818 amends the Tax Code to allow Americans who are covered by a catastrophic health insurance plan to maintain a medical savings account, which we normally call MSAs, to assist in paying for medical expenses not covered by their health plan.

Providing Americans with MSAs combined with catastrophic health coverage is an alternative to congressional health insurance. The MSA concept has, frankly, caught the imagination of the general public as well as many of the Representatives here in Congress.

It is an attractive alternative to conventional health insurance, I believe, because it would contribute to two of the most important goals of health reform. First, it would assist in expanding affordable health coverage for Americans, and second, MSAs would promote personal responsibility in cost conscience purchasing of medical services.

The old-fashioned fee-for-service form of health insurance leaves physicians and their patients with little knowledge and, therefore, little concern about the costs of particular treatments or procedures. Historically, health insurance has been there to pay, so often neither the physician nor their patients have spent medical care dollars carefully.

In addition, as the old style indemnity insurance has grown in cost, it has fueled medical inflation. The old style insurance has itself become a factor in the decline in coverage as employers and individuals have found it more difficult to bear the burden of such costly health insurance.

Coverage by coordinated care arrangements, such as health maintenance organizations, have proved defective in curbing health care costs. But in our pluralistic society, many employers and individuals see choice of additional strategies to health care coverage as a plus in working the affordability game. MSAs are one such alternative.

This approach will enhance coverage by keeping it affordable. And unlike most employer plans, MSAs are truly portable, following an employee when he or she leaves a job, changes jobs, or retires.

MSAs also empower the individual in regard to medical care purchasing, I believe, and an individual with an MSA will benefit from taking responsibility for staying well and avoiding health costs or buying carefully when medical services are necessary.

These new incentives for individual consumers of health care should keep costs down, since those with MSAs are personally responsible for how much they spend on a significant portion of their health care needs.

H.R. 1818 provides Americans with more choices. Combined with the freedom to make their own medical care decisions, these choices can make health care more affordable for those with MSAs while increasing the awareness of health care costs.

I look forward to the testimony not only from our distinguished colleagues but from the other panels today to shed more light on MSAs and how they work.

Ordinarily Chairman Archer, the sponsor of the bill, would lead off the testimony. He is unavoidably delayed until a little bit later in the hearing, and, therefore, before hearing from our colleague, the principal cosponsor of the bill, Andy Jacobs of Indiana, I would recognize the Ranking Member, Mr. Stark.

Mr. STARK. Well, Mr. Chairman, since it is raining this week, I will include a little rain on the parade.

I appreciate your having these hearings, but I think medical savings accounts are a scam. They would transfer money from people who are sick or are liable to become sick or pregnant to those who have the good fortune to be healthy.

They are especially skewed to benefit healthy people in high tax brackets at the expense of taxpayers in general. And, worse, if they caught on, they would undermine the entire health care system by making insurance less affordable for anyone who has a high probability of having high medical expenses.

MSAs are a brilliant scheme to skim healthy people out of the insurance pool, leaving those who are sick or who are planning a baby at increasingly expensive traditional plans. And the MSAs would force traditional plans to increase their premiums to make up for the money that MSAs take out of the pool.

MSAs allow people to pay for otherwise uninsured's medical expenses out of tax free income. Insurance companies that would benefit financially from these plans have been quick to tout the advantage of this approach. In fact, one of the major proponents is a company already notorious for its efforts to exclude sick people from its insurance pool. But more objective analysts, including the American Academy of Actuaries, have pointed out that while MSAs may be great for people who are both healthy and in a high tax bracket, those who are sick and taxpayers in general will be paying for the windfalls that go to those rich folks. And while the healthy and wealthy few save money, resources available for health care in general will shrink, and most families will risk paying much more in health care costs out of their own pockets.

The proponents of MSAs rest their arguments on a large fallacy, and the fallacy is that overall health care expenditures will be reduced if tax preferred medical savings accounts are made available. There is no evidence to this effect, and certainly no evidence that the public in general has any concept of how to purchase health care or what it costs.

Health care decisions are made in large part by health care providers, not the patients. In fact, there is a potential for health care costs to actually rise for the individuals that move out of highly managed HMOs or move out of plans with significant provider discounts and into MSA plans with very loose utilization and fee controls.

Putting off a tetanus shot or a flu shot may save a buck today, but it may very well end up costing a whole lot more tomorrow. For the healthy, there may be a reduction in the premium for their health care coverage, but for those remaining in the standard policies, they will see a premium jump. Again, overall, there is no proof that health care expenditures will be reduced as a result of the availability of MSAs.

Thank you, Mr. Chairman.

Chairman THOMAS. And for the rest of the story, the gentleman from Indiana, Mr. Jacobs.

STATEMENT OF HON. ANDREW JACOBS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. JACOBS. Thank you, Mr. Chairman.

Obviously, Mr. Stark's and my view of this is slightly different. I am not in the habit of perpetrating scams, but it is in the eyes of the beholder, I suppose.

The explosion in medical inflation occurred in the United States, I believe the record will show, around 1965–1966, in the late sixties. Coincident with that explosion was the advent of Medicare, a very deep pocket. It was begun on an unfortunate model; namely, that of the Pentagon—the infamous "cost plus contract," which meant that whatever your costs are would determine your profit; the higher the cost, the higher the profit. It was an invitation to excess and to waste.

By 1983, the Reagan administration—I had the honor of being one of your predecessors, Mr. Chairman—the Reagan administration proposed the diagnostically related groups and the prospective payment to cease that kind of nonsense and inject a little bit of market incentive into the Medicare systems. If we had not passed that law in 1983, God knows what would be left of Medicare now more than a decade later.

The literature is rife with articles about third party payers. My colleague, Mr. Christensen, has a very bad cold now. If he goes to see a doctor, he will get over it—with all due respect to my friend from Nevada, if he goes to see a doctor—we are not talking about broken legislation now—he will get over it in 6 days. And if he does not go to see a doctor, he will get over it in 6 days.

Now, if you are paying his bill and the doctor tells great jokes, then maybe John would be tempted to go on over anyway. Or if I have a hangnail and my doctor tells good jokes I might go anyway. The point being that there is a difference between using money that does not seem like yours and money that is yours. That is what the medical savings account is all about.

My friend Pete says, well, there is no proof that that will save money. To me, that is like saying there is no proof that if you do push-ups you will be in better shape. It has been proved at the Forbes organization, for example.

I listened to a woman in a meeting explain that with her medical savings account she went to see a doctor who said she needed an operation that cost $8,000. Well, she had the medical savings. That is her money. So, she goes to a second one and says, you are crazy, that guy is ripping you off, I can do it for $4,000. But she even went to a third doctor and he said, you're really crazy, you do not

need an operation at all. Now, Pete, there is $8,000. Chalk that up. And that can be multiplied by millions of people.

I hear it said that it will shrink the pool of insurance money to pay medical bills. Of course it will. That is exactly what we are trying to do. If you shrink the prices, the proportion of the U.S. economy that puts money into medical care will shrink. You will not need as much insurance at that point.

And finally, Mr. Chairman—by the way, when I chaired this Committee I always allowed each witness two "finallies" and one "in conclusion." I will see if I can make it on the finally.

In the old days, if you had a fender-bender you went to the insurance company and the first question the guy with the clipboard would ask is, is this an insurance job, and you knew what the price was going to be if it was, and you knew what the price was going to be if it was not.

Cha-cha and off.

Chairman THOMAS. And, in conclusion, I thank the gentleman from Indiana.

The gentleman from Nebraska, Member of the Subcommittee, Mr. Christensen.

STATEMENT OF HON. JON CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. CHRISTENSEN. Thank you, Mr. Chairman, and as Mr. Jacobs has already stated, I am experiencing a summer cold, so if I start to hack and cough I will apologize profusely to the Committee.

Thank you for your leadership in this area and for having these hearings today. Medical savings accounts, or MSAs, are a revolutionary idea whose time has come. Although there are countless variations, MSAs generally allow individuals to save money in a tax exempt account, much like an IRA. Instead of purchasing an expensive first-dollar type of insurance policy, the individual would purchase a less costly, high-deductible catastrophic health insurance policy to cover major medical expenditures. The individual can use the money in the MSA to cover routine medical expenses with the catastrophic policy covering major medical expenses.

MSAs have many benefits. First, MSAs create strong incentives for cost and quality conscious health care decisionmaking. Most health care experts will tell you that the main reason health care costs have skyrocketed in recent years is because there is little or no price sensitivity in health care purchases. Under the third party payer payment model that currently dominates our health care system, transactions between health care providers and individuals are paid by a third party such as an insurance company or the government.

Current estimates reveal that 95 percent of hospital bills and over 80 percent of physician fees are paid by some third party. This system perpetuates the misconception that someone else is picking up the health care tab and, thus, the individual does not have to worry about the cost or the need for care. This has created increased health care consumption, which in turn has caused inflationary pressure on health care costs.

MSAs alleviate this problem by giving people control over their own health care dollars. When they know and understand it is

their own money they are spending, individuals are much more careful and selective about the medical services they use. The increased price sensitivity results in more efficient use of health care resources, and, thus, lower health care costs.

The Rand Corp. has confirmed this. In a study conducted in the early eighties, researchers studied the health care decisions of over 2,000 families. What they discovered was that the lower the health insurance deductible, the greater the utilization with no discernible difference in health outcomes. When these findings are extrapolated, the Rand study shows when people are spending their own money on health care, they spend 30 percent less with no adverse effect on health.

Second, MSAs encourage savings by individuals. Our country is facing a savings crisis. We have the lowest savings rate in the industrialized world. As a matter of public policy, we must do everything we can to encourage people to save money. MSAs provide a vehicle for employees to save their hard-earned dollars. Unlike flexible spending accounts where the funds in the account remain the property of the employer and any unused funds traditionally revert to the employer, all money in an MSA belongs to the individual. This money can be saved by the individual to cover future health care expenses.

Third, MSAs are completely portable. One of the greatest concerns that I hear from Nebraskans and others about is "job lock," the situation which individuals are scared to leave their current job because they might lose their health insurance. MSAs, unlike traditional employer-provided health insurance, follow the individual. They allow individuals to save money that can cover health care expenditures and insurance during temporary loss of employment.

And, finally, MSAs are a proven tool in cutting health care costs with no adverse effect on the individual's health. We have heard numerous examples from Dominion Resources to Quaker Oats to Golden Rule to even my colleague on my right and his company where they testified last month before our Committee.

In conclusion, I want to touch just briefly on the issue that we have been working on, that we will be working on later this year, and that is the Medicare problem. I believe that MSAs also hold a solution facing us with that problem.

Last month, we heard an individual from the National Center for Policy Analysis, Peter Ferrara, testify and highlight a proposal from Dr. John Goodman about how MSAs can help in reducing the consumption with Medicare. I truly believe that using the MSAs with the Medicare dilemma we are faced with to help create an advantageous system for seniors, allow more opportunity, more cost consciousness and place for emphasis on the individual.

I truly believe that MSAs are part of the answer to every phase whether it is private, Medicare, or the entire health care system. It is truly a revolutionary idea that has come.

I thank the Chairman for holding these hearings and thank you. I will be glad to answer any questions and would ask that my full testimony be entered into the record.

Chairman THOMAS. Without objection, all the written testimony of the Members will be made a part of the record.

[The prepared statement follows:]

Testimony of Representative Jon Christensen
Before the Health Subcommittee
of the
Committee of Ways and Means
June 27, 1995

Mr. Chairman, I want to thank you and the other members of the Subcommittee for this opportunity to testify today regarding a health care reform measure that represents a significant step in solving the problems facing our health care system. What I'm referring to, of course, is the Medical Savings Account.

Medical Savings Accounts, or MSAs, are a revolutionary idea whose time has come. Although there are countless variations, MSAs generally allow individuals to save money in a tax-exempt account, much like an IRA. Instead of purchasing an expensive "first-dollar" type of insurance policy, the individual would purchase a less costly, high-deductible catastrophic health insurance policy to cover major medical expenditures. The individual can use the money in the MSA to cover routine medical expenses with the catastrophic policy covering major medical expenses.

MSAs have many benefits. First, MSAs create strong incentives for cost- and quality-conscious health care decision making. Most health care experts will tell you that the main reason health care costs have skyrocketed in recent years is because there is little or no price-sensitivity in health care purchases. Under the third-party payment model that currently dominates our health care system, transactions between health care providers and individuals are paid by a third party such as an insurance company or the government. Current estimates reveal that 95 percent of hospital bills and over 80 percent of physician fees are paid by some third party. This system perpetuates the misconception that someone else is picking up the health care tab and, thus, the individual doesn't have to worry about the cost or need for care. This has created increased health care consumption, which in turn has caused inflationary pressure on health care costs.

MSAs alleviate this problem by giving people control over their own health care dollars. When they know and understand that it's their own money they are spending, individuals are much more careful and selective about the medical services they use. This increased price sensitivity results in more efficient use of health care resources and, thus, lower health care costs.

The Rand Corporation has confirmed this. In a study conducted in the early 1980s, researchers studied the health care decisions of over 2,000 families. What they discovered was that the lower the health insurance deductible, the greater the utilization with no discernible difference in health outcomes. When these findings are extrapolated, the Rand study shows that when people are spending their own money on health care they spend 30 percent less with no adverse effect on health.

Second, MSAs encourage savings by individuals. Our country is facing a savings crisis; we have the lowest savings rate in the industrialized world. As a matter of public policy we must do everything we can to encourage people to save money. MSAs provide a vehicle for employees to save their hard-earned dollars. Unlike Flexible Spending Accounts (FSAs), where the funds in the account remain the property of the employer and any unused funds traditionally revert to the employer, all money in an MSA belongs to the individual. This money can be saved by the individual to cover future health care expenses.

Third, MSAs are completely portable. One of the greatest concerns that I hear from Nebraskans and others about is "job-lock" -- the situation in which individuals are scared to leave their current job because they might lose their health insurance. MSAs, unlike traditional employer-provided health insurance, follow the individual. They allow individuals to save money that can cover health care expenditures and insurance during temporary lapses in employment.

Finally, MSAs are a <u>proven</u> tool in cutting health care costs with no adverse affect on the individual's health. We've all heard how *Forbes* magazine, Dominion Resources,

Quaker Oats, Golden Rule Insurance Company and others have successfully implemented MSA-type accounts to the benefit of both employer and employee.

For example, last month Tom Erhart, Vice-President for Human Resources for RCI, a Michigan-based automotive specialty company, testified before this Subcommittee on MSAs. Mr. Erhart told the Subcommittee that since implementing its MSA program, the company was able to: (1) increase the level of benefits to its employees while reducing its health insurance costs by nearly 15 percent; (2) return, on the average, over $1,000 to nearly 75 percent of its employees; and (3) significantly reduce employer and employee paperwork. As Mr. Erhart put it, it's a "win-win situation for employer and employee."

It is for these reasons that I am a proud original cosponsor of H.R. 1818, Chairman Archer's Family Medical Savings and Investment Act of 1995. This historic piece of legislation provides that individuals covered by a catastrophic health plan, *i.e.*, a plan that has a deductible amount of at least $1,800 per individual or $3,600 for more than one person -- will be eligible for tax relief for maintaining and using an MSA for medical expenses not covered by the health plan. Where contributions are made by an employer, contributions would be excluded from the employee's gross income. Where contributions are made by an individual, contributions would be tax deductible. In both instances withdrawals from an MSA would be excluded from income if used for medical expenses for an individual and their family. I'm confident that this important measure will be passed in the 104th Congress as yet another plank in the incremental health care reform platform Republicans have proposed in order to "zero-in" on specific problems with our health care system.

Before I close, I want to briefly touch on the tremendous potential MSAs hold in helping us save Medicare from financial ruin while at the same time giving our nation's seniors improved health care benefits and quality.

By now hopefully we all understand that Medicare is going broke. The Trustees of the Medicare Trust Fund, including four of President's Clinton's own appointees, recently

announced that, beginning next year, Medicare will spend more than it takes in. By 2002, it will be completely bankrupt. If this happens, no one in America will have Medicare--*No one*. Something must be done to protect, preserve and improve this vital program. It must be done in a manner that gives our nation's seniors more choices in health care; that gives them better, higher quality health care; and, most importantly, ensures that Medicare will be there for them and for generations to come.

I'm hopeful that MSAs will play a vital role in achieving these goals. During last month's hearings on the potential role that MSAs might have in the Medicare program, I was especially impressed with testimony of Peter Ferrara, a Senior Fellow with the National Center for Policy Analysis out of Dallas, Texas. Mr. Ferrara highlighted a proposal that he and Dr. John Goodman, the father of MSAs, drafted. Under that proposal, seniors would be free to withdraw their share of Medicare spending each year and use it to purchase private coverage of their choice, including an MSA option. Under the MSA option, the senior would use part of the funds to purchase a high-deductible health insurance policy. The remaining funds would be placed in an MSA and used to pay for medical expenses below the deductible. The senior citizen would be able to withdraw any remaining MSA funds at the end of the year and use them for any purpose. Like MSAs in the non-Medicare setting, MSAs for Medicare recipients would create effective incentives for recipients to be cost- and quality-conscious in their health care decisions while at the same time providing seniors with greater choice of health care providers and services.

In closing, I want to again thank you Mr. Chairman and my colleagues on the Subcommittee for the opportunity to testify before you today. When I began my campaign for the United States Congress nearly two years ago, this nation was facing one greatest public policy challenges it has ever faced. Health care reform was the hot topic and everyone was looking for ways to halt skyrocketing costs and address such problems as portability and pre-existing conditions. The current occupants of the White House were advocating the government takeover of one-seventh of our nation's economy as the solution to these problems. I took a different route. I campaigned on a little-known reform called the Medical Savings Account because it was the free-market alternative to the government-knows-best type of reform that was being proposed. Health care decisions are best made by individuals, not governments. It made sense two years ago. It makes sense today.

Thank you.

Chairman THOMAS. Now we will hear from our friend, the Chairman of the House Agriculture Committee, the gentleman from Kansas, Mr. Roberts.

STATEMENT OF HON. PAT ROBERTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. ROBERTS. I thank the Chairman not only for his leadership but for his strong support of the MSA concept, the medical savings account concept, and would only opine, in regard to Mr. Stark's observation that he is raining somewhat on the MSA parade, that you do not necessarily have to be that Al Capp character in regard to Li'l Abner, which really dates me, Joe Boozlefoop, or whatever his name was—Mr. Jacobs has the name, you know, I can't remember that—but, at any rate, this is not really doom and gloom. It is just not a program to get the wealthy and the healthy to take away or skim and scam or film and flam in regards to your regular policyholders.

My remarks come, obviously, because of my association with the House Agriculture Committee. One quarter of the U.S. population, about 65 million persons, do reside in the rural areas. We have very special characteristics and special needs that pose challenges to providing our rural health care services. We are more likely than the urban residents to be simply uninsured. We are often out of the mainstream of employment-based health insurance coverage because we are self-insured farmers and ranchers or small business people or seasonally employed workers such as a custom cutter.

Many rural residents are employed by small businesses that do not provide health insurance benefits or are unemployed altogether. As a result, a higher proportion of our residents must purchase individual health insurance policies on their own. These policies are generally more costly than the group coverage and make the coverage less affordable in the rural area.

But we in rural America are used to developing our own solutions to our health care problems. Rural consumers are not looking for more Federal handouts or any more regulatory schemes. Rural Americans are looking for the proper tools to make their own decisions and to help themselves. The medical savings accounts are such a tool that will help our farmers and ranchers and our small business people certainly meet their health care needs.

The farmers and small business folks really prefer an approach to health insurance coverage that puts them in charge of their own health care dollars. The family savings account does just that. This approach will allow the individual to control their spending through the use of a high-deductible and catastrophic plan combined with the MSA trust to pay for the smaller medical bills. These plans encourage savings and responsible spending decisions. They help ensure that individuals and families have the adequate health insurance in times of economic hardship or unemployment. Since they are portable, they also really start to eliminate the fear of losing health benefits due to a job loss or a change. And finally, the individuals have the option to choose the plan that works best for them.

I know we are moving into a new managed care world. The MSA, the medical savings account will become an even more important

tool in rural areas. This is partly because there are not many doctors or hospitals to manage in a rural area.

I have often asked the question, how do you manage care that is not there? While I support efforts to really try to integrate the health services and strongly encourage the networking of facilities and providers, managed care is simply not readily available in much of our rural areas. Many rural health care consumers are a little nervous about the possibility of someone or some corporation simply coming into their community and telling them where they will have to go for care. If individuals are in control of their own health spending through a medical savings account, they are also in control of choosing their own doctor and their health care facility. Until the managed care becomes, and I would say if and when it becomes, more established in the underpopulated rural areas, the MSAs will protect and preserve the right of the patients to choose his or her own family doctor.

Mr. Chairman, we had hearings in the sometimes powerful House Agriculture Committee with the former Chairman Kika de la Garza, and we heard from all sorts of rural health care providers, and the support was across the board, the Farm Bureau, the Wheat Growers, other commodity groups; all farm organizations endorsed the MSA.

I want to thank you for your leadership in this regard. I want to thank you for restoring the tax deduction for the self-employed up to 25 percent; it will be 30 next year. That is part of the answer. The MSA is part of the answer. I urge swift and favorable passage of this act and I thank you, sir, for the opportunity.

[The prepared statement follows:]

TESTIMONY OF REP. PAT ROBERTS
FAMILY MEDICAL SAVINGS ACCOUNTS
HEARING BEFORE THE
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
JUNE 27, 1995

Mr. Chairman, thank you for the opportunity to discuss health insurance reform with you today, particularly Medical Savings Accounts (MSAs) and their impact on the health of rural Americans. I am pleased that this committee has introduced legislation which will greatly improve the health care insurance options for all Americans, rural and urban alike.

One-quarter of the U.S. population--about 65 million persons--reside in rural areas. Rural communities have unique characteristics and special needs that pose challenges to providing rural health care services. Rural residents are more likely than urban residents to be uninsured. They are often out of the mainstream of employment-based health insurance coverage because they are self-insured farmers and ranchers or seasonally employed workers such as custom harvesters. Many rural residents are employed by small businesses that do not provide health insurance benefits or are unemployed altogether. As a result, a higher proportion of rural residents must purchase individual health insurance policies on their own. These policies are generally more costly than group coverage and make health insurance coverage less affordable in rural areas.

However, compromise is a way of life for rural residents and we in rural America are used to developing our own solutions to health care problems. Rural consumers are not looking for more federal handouts or regulatory schemes. Rural Americans are looking for the proper tools to make their own decisions and help themselves. Medical Savings Accounts (MSAs) are one such tool that will help farmers and ranchers meet their health care needs.

Farmers and small business proprietors prefer an approach to health insurance coverage that puts them in charge of their own health care dollars. The Family Medical Savings and Investment Act does just that. This approach will allow individuals to control their spending through the use of a high deductible catastrophic plan combined with the MSA trust to pay for smaller medical bills. These plans encourage savings and responsible spending decisions. MSAs help ensure that individuals and families have adequate health insurance in times of economic hardship or unemployment. Since MSAs are portable, they also eliminate the fear of losing health benefits due to a job loss or change. Furthermore, individuals have the option to choose the plan that works best for them.

As we move into a new "managed care world", MSAs will become an even more important tool in rural areas. This is partly because there are not many doctors or hospitals to manage in rural areas. I've often asked the question, "How do you manage care that is not there"? While I support efforts to integrate health services and strongly encourage the networking of facilities and providers, managed care is simply not readily available in much of rural America. Many rural health care consumers are a little nervous about the possibility of someone or some corporation coming into their community and telling them where they will have to go for care. If individuals are in control of their own health spending through an MSA, they are also in control of choosing their own doctor and health care facility. Until managed care becomes more established in underpopulated rural areas, MSAs will protect and preserve the right of the patient to choose his or her own family doctor.

The House Agriculture Committee held a hearing on rural health care last March where I heard from a variety of rural health providers and consumers from across the country. The theme of "freedom of choice" and "individual responsibility" came through loud and clear. Several witnesses strongly recommended that Congress create MSAs or Medi-Save accounts in order to encourage this responsibility and preserve choice. A soybean farmer from Georgia told me that "farmers can be part of the solution by designing and managing their own coverage". While MSAs may not be a panacea for health insurance, I believe they are a part of the solution.

Thanks to the work of your committee, we are making progress in our efforts to improve health care options for those in rural areas. By restoring the tax deduction for the self-employed to 25 percent earlier this year, your committee has taken the first step to bring tax fairness to rural residents. I am still hopeful we can increase this deduction to 100 percent in the near future. The Family Medical Savings and Investment Act is another step to increase insurance options and improve the health care of rural Americans.

Again, thank you for this opportunity to share my thoughts with you this morning. As always, it has been a pleasure meeting with this committee. I applaud you in your efforts to establish Medical Savings Accounts and look forward to working with you.

Chairman THOMAS. I thank the gentleman.
The gentleman from Michigan, Mr. Chrysler, welcome back.

STATEMENT OF HON. DICK CHRYSLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. CHRYSLER. Thank you, Mr. Chairman, and Members of the Committee. Thank you for inviting me here today to relate to you and the American people the positive experience my company enjoys with medical savings accounts.

At my company, RCI, we use medical savings accounts as our answer for health insurance and we are proof positive that they work. Michigan had the wisdom and the vision to enact medical savings accounts in 1993. After our first year of implementation, we can already say that the program has been an enormous success. While our medical savings account plan carries substantially higher benefits than our former insurance plan, our annual health care expenditures per employee was actually reduced by $600 from $4,800 to $4,200. That is a savings of 14.3 percent in just 1 year.

At RCI, an employee with dependents received $3,000 in a medical savings account. Single employees receive $1,500 in their accounts. With this MSA, the employee can purchase any kind of health service they want, medical, dental, prescription drugs, anything they need, as long as it is medical. Any money left in the MSA at the end of the year is the employee's money to keep. Seventy-five percent of the employees at RCI received money back, usually over $1,000, at the end of our first year.

I will say that the average American will spend about $1,000 per year on health care. Coupled with the employee's medical savings accounts is a $1,500 insurance policy put into place in the event the account is exhausted. Any additional medical expenses above the MSA are paid by this policy. It is similar to car insurance, where you have a high-deductible.

For the employees, this health care plan is beneficial in two ways: First, by being in control of their health care dollars they can receive a return at the end of the year; second, it creates an incentive to take better care of themselves through preventive measures, to avoid costlier medical procedures later.

When it is the employee's own money, they will spend it wisely, asking how much it will cost, and shopping around for the best price. That is the best way to control cost. Free enterprise, alive and well.

With an average healthy life, an individual who puts money away each year from his or her medical savings accounts, compounding it over a lifetime of work, will have a substantial nest egg of well in excess of $100,000 at retirement. And that is exactly when it is needed, because about 80 percent of our health care dollars are used in the last 6 months of life.

Currently, no tax advantages exist to rollover remaining MSA accounts to the following years, leaving most employees to take the cash option at the end of the year. If Congress authorizes MSAs and grants them tax deductible status, these programs will have an unlimited appeal to both employees and employers, providing a win-win situation for everyone involved.

I truly believe we would see a dramatic reduction in health care costs nationwide with the expanded use of MSAs. In addition, if a person is unemployed for a period of time, he or she could use his or her medical savings account to continue their health insurance until they find a new job. In addition, a huge pool of money would be created by MSAs which would be a great resource capital for entrepreneurs.

Medical savings accounts could also help very costly government programs, such as Medicare and Medicaid, work better. For Medicaid, the government would give an individual on welfare an MSA voucher which could be taken to an insurance company of the individual's choice to get an MSA insurance policy. If that individual has money coming back to them at the end of the year, it should be held until they find a job, giving them another financial incentive to find work.

With MSAs in place over a period of years, the need for Medicare would be diminished greatly. If a person had accumulated approximately $100,000 in their medical savings account by age 65, that individual could purchase a super MSA from an insurance company with $100,000 deductible for the remainder of his or her life.

We need to create these types of programs to solve our long-range crisis in Medicare and Medicaid. Based upon my firsthand experience with medical savings accounts at RCI, I can honestly tell you the theory behind them works in real world application.

In my opinion, medical savings accounts provide the best health care program when it comes to the high level—when it comes to high-level benefits, employee satisfaction, freedom of choice, efficiency, and cost effectiveness. The Archer-Jacobs bill is a tremendous step toward expanding the use of this innovative approach to health care in our country and has my full support. The only scam is that the MSAs were never allowed to be reported out of a Committee in the past to be voted on by the full floor of the House.

Medical savings accounts can play a positive role in reducing health care costs and improving the health care delivery system nationally. Congress should take action now to expand MSAs as the preeminent choice in providing a free market solution for health care for all of our citizens.

Thank you.

Chairman THOMAS. I thank the gentleman.

Arriving with us on the panel is the Chairman of the Full Committee, but I would request of the Chairman—I would prefer he bat cleanup, if he does not mind, because he is going to be speaking directly to H.R. 1818 and some Members are speaking in general on the MSA. And we do want to focus as the subject of this hearing on H.R. 1818. Therefore, I will turn to the gentleman from Arizona, Mr. Salmon.

STATEMENT OF HON. MATT SALMON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. SALMON. Thank you very much, Mr. Chairman. I appreciate the opportunity to testify before your Subcommittee.

I would like to congratulate Chairman Bill Archer and Representative Andy Jacobs for introducing their bill, H.R. 1818. I believe it is a fantastic step in the right direction.

I am also proud to be a cosponsor of the same bill. I would like to make a comment because I have been involved in this debate for a few years, having sponsored a medical savings account bill in the Arizona State legislature, and having successfully shepherded that through. I have heard all the arguments from A to Z as to why this is not going to work, and it predominately comes from those insurance companies that I think are paralyzed with fear they will lose market shares, and I think that is really what this gets down to.

I have heard the arguments that people will skimp when it comes to taking care of their preventive medicine, that they will not make intelligent decisions in purchasing their health care. I think that is balderdash. In fact, I do not think people are as dumb, as government believes they are. I think that individuals make better decisions than bureaucrats do and I believe that that is the same for government bureaucrats and insurance bureaucrats.

I think individuals have more of a vested interest in the successful outcomes and the health of their families than bureaucrats could ever hope to. I think the best attributes of a medical savings account are, number one, it empowers people; it allows them to shop for the best deals and it gives them incentives to control costs.

Second, it cuts dramatically administrative costs. During the course of my campaign, I spent a lot of time in hospitals, health care centers, doctors' offices, and I found that across the board, doctors are spending about 35 to 40 percent of their time on administration, on red tape and bureaucracy, and on sending paperwork to either Medicare or to insurance companies.

Let me illustrate how we can save if you are dealing on a cash basis with your health care provider.

About 7 years ago my last child was born, Matthew. The cost, through my third party payer, as with many people, was $3,500. Seven years ago, for a healthy delivery.

My sister-in-law had a baby 2 months later, same hospital, same doctor, only they didn't have insurance so they paid cash, $1,500. You cannot tell me that we are not going to see a cut, a reduction in our costs, by cutting out needless bureaucracy and paperwork.

Let's talk about the need, though, for a Federal tax incentive. I was successful in getting a State law passed in Arizona. I believe we are one of seven States now that provide State tax benefits for medical savings accounts, but it is not even close to the whole enchilada.

I think we understand that in order to really give people the incentives toward medical savings accounts, we have to have a level playingfield with other kinds of medical insurance and give the same types of tax preference to medical savings accounts we do to other kinds of coverage.

Several companies have found when they went onto MSAs they have cut their costs without the Federal tax deduction, and the Archer bill will expand this greatly. Almost 90 percent of Americans spend less than $3,000 a year on their health care expenses.

I also feel, personally, that medical savings accounts would be a great step in helping us to resolve the crisis with our Medicare system. I think that Federal employees should be able to put their government contribution toward a catastrophic plan with an MSA.

And I would love to come back and talk about that at some other time.

I do believe that individuals can make these decisions. They will make good decisions for their families if we simply level the playingfield and give the same kind of preference as we do to other types of care.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Written Statement of Rep. Matt Salmon before the Health Subcommittee of the Ways and Means Committee

June 27, 1995

As a proud cosponsor of Chairman Archer's Family Medical Savings and Investment Act of 1995, H.R. 1818, I appreciate the opportunity to testify before this subcommittee. The Ways and Means Committee, and this Health Subcommittee, should be commended for investigating Medical Savings Accounts (MSA's), and Chairman Archer and his staff deserve our thanks for their persistence in advocating Medical Savings Accounts.

Last year I stood beside Arizona Governor Fife Symington as he signed our state's Medical Savings Account Act into law. I had introduced the bill in the State Senate because my examination of MSA's led me to conclude that they could improve considerably our health care delivery and insurance systems for millions of people in Arizona and across America. But I also recognized at that time that no state or states, and no employer or employers, could unleash the full promise of MSA's without changes in federal law. Thus, I promised I would take my fight for MSA's to Congress; and, needless to say, I have been extremely encouraged to find that many others have been fighting, and continue to fight, for the same goals.

What we are fighting for is to put MSA's on a level playing field with other forms of insurance, be they HMO's or fee-for-service plans. We are not attempting to mandate MSA's on anyone, but rather to offer Americans an additional option.

As you will hear throughout today's hearing, a high-deductible catastrophic insurance plan, combined with a Medical Savings Account, can empower patients to reduce their own health care expenditures. Health care costs will fall as the persons receiving medical care are put in charge of shopping for fairer rates and negotiating their own expenses. This will particularly be true in the case of MSA's because participants who are successful will be able to keep their savings.

The federal tax deduction envisioned in the Archer bill will make MSA's attractive. Currently, some employers provide MSA's for their employees, even though MSA's do not enjoy the federal tax deduction that traditional employer-provided health insurance receives. Once the playing field is leveled, as with the Archer bill, the cost-cutting potential of MSA's will fully flourish, and the empowerment it provides to employees will quickly make MSA's a popular choice for many Americans.

By giving MSA's the tax incentives that other types of health insurance currently receive, we will reverse the upward spirals in health care costs. In fact, I believe MSA's are part of the answer to how we can preserve and protect our Medicare system; and I would love to see MSA's made available to federal workers, as a first step towards providing this option to all Americans. I intend to push these ideas through legislation currently being drafted, and I hope you would invite me back to talk about them at a later date.

Thank you again for holding this hearing, and I urge you to support Chairman Archer's fine MSA bill. Our constituents will benefit from its prompt passage. Thank you very much.

Chairman THOMAS. Thank you very much.
And our friend from Iowa, Hon. Dr. Ganske.

STATEMENT OF HON. GREG GANSKE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. GANSKE. Thank you, Mr. Chairman. And I want to applaud the Chairman of the Full Committee, Chairman Archer, and Mr. Jacobs for their leadership in this area. I have had the opportunity to discuss MSAs with Chairman Archer on several occasions and his insights have proven very valuable to me and I am sure will help guide this Congress.

I want to look at MSAs from a little different angle. I may be the only Congressman who has actually practiced medicine under a free market.

Prior to becoming a Congressman last November, I was a plastic surgeon and I know from personal experience that when the consumer pays the bill, medical costs are controlled. While about 90 percent of my practice was reconstructive, some of my practice was cosmetic surgery. I can assure you that when the patient spends his own money, the free market can work to hold down medical costs.

Before most patients ever crossed my doorway, they had phoned every other plastic surgeon within a 50-mile radius to find out what the total cost of their package would be. Consequently, medical inflation in this field has been virtually zero for the last decade.

All of my patients had questions about options, outcomes, and risks, but unlike my reconstructive patients, those who came to me for cosmetic procedures were also concerned about price because nobody else, the government or insurance company, was paying for their treatment. So they were very much aware of the financial aspects. There lies the basic reason that health care costs have risen far above regular inflation.

There is a fundamental disconnect in our country between the payor and the patient. When somebody else is perceived as the payor, the goods and services are perceived as being free and demand explodes and the patient does not care what it costs. The recognition of the "it is free syndrome" is why even managed care is moving to higher deductible policies.

The problem with higher deductible policies is that preventive care may be avoided leading to more serious and expensive health care costs later on. That is why a mechanism is needed that provides an individual with the ability to pay the deductible for preventive and necessary care and, at the same time, provides them with a carrot not to overutilize the services. That is why I am very hopeful that Congress will enact legislation to allow for the tax free funding of medical savings accounts, because it is MSAs that provide the mechanism to cover that high deductible while, at the same time, making the patient cost conscious.

Critics of savings accounts will claim that health care has become so complex that patients just are not capable of making quality or cost-conscious decisions about their treatment. I would say it is the current system of third party payment and not the complexity of medicine that has created these incentives.

In my medical practice, patients who spent their own dollars on sometimes very complex procedures were quite knowledgeable about the quality issues in addition to the cost.

My own sister has a child with Down's syndrome. She has taken over the health care of that child. She is very knowledgeable about Down's syndrome and works very closely with her pediatrician. Where there is an interest, there will be knowledge.

Health care consumers can, and do, make wise decisions. By setting up MSAs as an option for Americans, this Committee will take a giant step toward eliminating overutilization of health care services. I look forward to working with this Committee on this problem.

Thank you.

[The prepared statement follows:]

STATEMENT OF HON. GREG GANSKE,
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. Chairman, thank you for holding this important hearing and for allowing me to testify.

I first want to applaud the Chairman of the Full Committee, Mr. Archer, for his leadership in this area. I have had the opportunity to discuss Medical Savings Accounts with him on several occasions. His insights have proven valuable to me and I am sure will help guide this Congress.

As a plastic surgeon prior to becoming a Congressman last November, I know from personal experience that when consumers pay the bill, medical costs are controlled. While most of my practice was reconstructive and paid for by third party payers, I also did some cosmetic surgery. I can assure you that when patients spend their own money, the free market can work to hold down medical costs. Before most patients ever walked into my office, they had probably called every other plastic surgeon within fifty miles of Des Moines. They shopped for the best package price which included all their expenses and also considered the quality of each doctor they called.

All of my patients had many questions about options, outcomes, and risks. But unlike my reconstructive patients, those who came to me for cosmetic procedures were also very concerned about price. Because no one else (the government or an insurance company) was paying for their treatment, financial aspects of one treatment option versus another were of much greater concern to them.

And that is the basic reason that health care costs have risen far faster than inflation. There is a fundamental disconnect between the payor and the patient. When somebody else is perceived as the payor, the goods and services are perceived as being free and demand explodes and the patient doesn't care what it costs.

Recognition of the "it's free syndrome" is why even managed care is moving to higher deductible policies. The problem with high deductible policies is that preventive care may be avoided leading to more serious, and expensive, health care needs later on. Therefore, a mechanism is needed that provides an individual with the ability to pay the deductible for preventative or necessary care and at the same time provides him with a carrot not to over-utilize services.

Accordingly, Congress must enact legislation to allow for funding of Medical Savings Accounts (MSAs) with pre-tax dollars by employers or employees, or both. People should be able to select an insurance policy with a high deductible and lower premiums, placing the savings in an MSA for routine medical expenses. Individuals holding down their health care costs are rewarded by keeping unspent balances in the MSA. Those funds can continue to grow, eventually funding long-term care insurance or a Medicare MSA for retirees.

Critics of MSAs will claim that health care has become so complex that consumers aren't capable of making quality and cost-conscious decisions about their treatment. It is the current system of third-party payment, and not the complexity of medicine, which has created disincentives for consumers to become knowledgeable. In my medical practice, patients spending their own dollars were very responsible in learning about the costs and benefits of each procedure. My sister has taken charge of the care of my nephew with Down's Syndrome, developing a keen understanding of the treatments which are worth the cost, and those that are not. These anecdotal findings are confirmed in scientific studies such as the one performed by the RAND Corporation. They found that individuals with higher deductibles were as healthy as those with lower deductibles, but were smarter consumers and avoided unnecessary services.

Health care consumers can, and do, make wise decisions when they have a financial incentive to do so. By setting up MSAs as an option for more Americans, this Committee will take a giant step in the effort to eliminate over-utilization of health care services.

Other critics of MSAs contend that MSAs will be chosen by the healthy and that this adverse selection would drive up the cost of other types of insurance. One could make exactly the same argument about managed care, or for that matter, the marketing and pricing strategies of "traditional" insurance. In practice, the potential of adverse selection for MSAs does not seem to be a problem for those companies already using non-tax deferred accounts.

It is clear that if this country is going to reduce its health care inflationary spiral, someone is going to control the spending. Government bureaucrats have been racheting the tourniquet for the past decade, and managed care gatekeepers are increasingly making those decisions in the private sector. The question is not whether choices are going to be made. The simple fact is that they will and nothing that this Congress does can change that. But we can address the question as to who makes those choices. Congress should enact Medical Savings Account legislation for individuals and retirees, encouraging health care consumers to be just as knowledgeable and cost-conscious as my patients were. . . and to make those choices for themselves.

Thank you again, Mr. Chairman, for the opportunity to submit these remarks. I look forward to working with you and the Members of the Committee to see that the goal of Medical Savings Accounts becomes a reality.

Chairman THOMAS. And now it is our privilege to hear from the Chairman of the Ways and Means Committee, the gentleman from Texas, the sponsor of H.R. 1818, Chairman Archer.

STATEMENT OF HON. BILL ARCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Chairman ARCHER. Thank you, Mr. Chairman. It is rare that the Chairman of the Full Committee testifies before a Subcommittee, but this is, in my opinion, a very rare proposal, an extremely important proposal.

As we move into the Byzantine halls of health policy and seek reform to strike at the flaws in the system, we should recognize the great strengths of the system, too. And I applaud the Members and the Chairman of the Subcommittee for their work in trying to improve on a very good system by world standards.

We know that people want more personal choice and control over their health care spending, and the bill before you today, H.R. 1818, the Family Medical Savings and Investment Act, does just that. And I am pleased that my colleague and my longtime friend, Andy Jacobs, has joined me in developing this proposal. We have been working on this for at least 3 years now, having introduced it some time back, and I believe we have continued to improve it as we have gone along.

It will work for Texans and Hoosiers, for Californians, and Virginians because it increases personal choice and personal responsibility for their health care spending. It provides American families with an opportunity not only to determine what health services they need, but also to do their part to put a lid on health care costs, costs that have continued to skyrocket due to overutilization and lack of accountability.

H.R. 1818 allows individuals who are covered by catastrophic health plans to maintain a personal medical savings account to assist in paying out-of-pocket expenses. And within limits, the contributions are excludable from gross income if made by the employer and deductible if made by the individual.

It allows families to have freedom to go to any doctor, hospital, or drug store they prefer. Families have control of how their health care dollars are spent. If they find themselves facing health care costs when they are unemployed or during retirement, the reserves accumulated in their medical savings account balances can be used to meet those needs.

And it is truly portable. You can take your medical savings account with you if you change jobs or retire. Paperwork is reduced. Expenses are simply paid out of the MSA. Premium increases in the catastrophic plan are lower because the premium base, with the high-deductible policy, is lower.

Americans with conventional health insurance have few incentives to buy services carefully. I believe this bill puts consumers in the loop and provides the American family with a valuable tool to use to help make the family paycheck stretch further; Freedom, choice, personal responsibility, and savings. Those are the hallmarks of the Family Medical Savings and Investment Act, H.R. 1818.

And I thank you for these hearings, Mr. Chairman. I look forward to working with you in developing what I believe will be a very constructive approach to health policy.

[The prepared statement follows:]

BILL ARCHER
7TH DISTRICT, TEXAS

CHAIRMAN
WAYS AND MEANS
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June 27, 1995

Statement of the Honorable Bill Archer
Committee on Ways and Means
Subcommittee on Health
Hearing on H.R. 1818

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to be here today to discuss an issue that is important to all of us.

Less than a year ago, the American people dismissed a plan to create a new government run health care system.

The people spoke and we listened.

Today as we begin to undertake health care reform that is carefully targeted towards identified problems, we recognize that people want more personal choice and control over their health care spending. The bill before you today (H.R. 1818), the Family Medical Savings and Investment Act, does just that. I'm pleased that my colleague and friend -- Andy Jacobs -- joined me in developing this proposal -- one that we believe will work. It will work for Texans and Hoosiers -- for Californians and Virginians. It increases personal choice and personal responsibility for their health care spending.

This bill provides American families with an opportunity not only to determine what health services they need, but also to do their part to help put a lid on health care costs -- costs that have continued to sky-rocket due to over-utilization and lack of accountability.

H.R. 1818 allows individuals who are covered by a catastrophic health plan to maintain a medical savings account to assist in paying for out-of-pocket expenses.

Within limits, contributions would be excludable from gross income if made by the employer -- and deductible if made by the individual.

In general, the amount of the individual or employer contributions that could be deducted or excluded for a taxable year would be the lesser of the deductible under the catastrophic plan or the $2,500 if the MSA covers only the individual. The deduction would be $5,000 if the MSA covers the individual and the spouse or a dependent of the

individual. Withdrawal from an MSA would be excludable from income if used for medical expenses for the individual and his or her spouse or dependents.

The bill allows families to have the freedom to go to any doctor, hospital or drugstore they would like. Families have control of how their health care dollars are spent. If they find themselves facing health care costs when they are unemployed or during retirement, the reserves accumulated in their medical savings account balances can be used to meet those needs.

It is truly portable. You can take your medical savings account with you if you change jobs or retire. Paperwork is reduced -- expenses are simply paid out of the MSA. Premium increases on the catastrophic plan are lower because the premium base with a high deductible policy is lower.

Americans with conventional health insurance have few incentives to buy medical services carefully.

I believe that this bill puts consumers in the loop and provides the American family with a valuable tool to use to help make the family paycheck stretch further.

Thank you again for this opportunity to appear before your Subcommittee. I'll be glad to respond to any questions the Members may have.

Chairman THOMAS. I thank the Chairman for his testimony.

I thank all the Members for their testimony.

Are there any Members who wish to inquire of the Members? The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman.

One of the points that was brought out by you, Mr. Salmon, was the administrative costs. I do not think that that can be downplayed at all, because every hearing we have on health care somebody brings up administrative costs and the bureaucracies that are set up in the private sector as well as the public sector. Because one of the criticisms that we always hear people that criticize Medicare and Medicaid and the whole Federal bureaucracy is that they respond by saying that we have this huge bureaucracy in the private sector. I think that is one place that medical savings accounts will help address, is the huge costs that we have in both the public and the private sector.

Chairman Archer, could you please address—how potentially this could be applied after somebody has been in the system for years, when they get older? Because one of the problems we have now is in long-term care for the elderly. How could this be applied if somebody has been in it for 20 years and now they have a medical savings account built up versus the system we have now?

Chairman ARCHER. Well, each individual that was able to accumulate any savings, and, obviously, not every individual could do so, but I think most would, will then have access to that later on in life, which would be very helpful to offset some of the additional expenses that come later in life.

We also are in the process of trying to develop, in fact we will develop, a medical savings account for retired persons, for senior citizens. It will have to be somewhat different than this, but I think it should be an option for Medicare enrollees also, should they elect to use it.

Mr. ENSIGN. Thank you.

Dr. Ganske, you mentioned that you were one of the only doctors, well, maybe a different profession, but certainly I experienced the same things in veterinary medicine that you experienced with your elective plastic surgery.

Can you address, because this was something I experienced, the communication between the doctor and the patient, when you are having to educate them on the cost as well as everything else in that elective part of your practice. One of the things you hear about, is that we have lost the doctor-patient relationship that used to exist.

Mr. GANSKE. Well, I think that a question concerning the patient's ability to be a wise consumer is going to relate to the kind of access they have to information that would allow them to comparison shop. And there are mechanisms and agencies we will develop that will allow a person not just to phone other surgeons or physicians in the medical area, but to get a comparisons.

Insurance companies have already developed a lot of data on comparison costs in the medical area. We already have RBRVS data and it would be very simple for a practitioner to simply calculate a conversion factor, for instance, on relative value standards for data that we already have on specific types of services that you

could give. That would then give a consumer a reasonable way of shopping in an informed way.

Mr. ENSIGN. Thank you, Dr. Ganske.

Mr. Salmon, what was your experience after this bill was passed in Arizona? Obviously, there is not as much incentive on the State level as there is from the Federal level, but, still, what was the experience from some of the companies?

Mr. SALMON. Their experience was a lot of the insurance providers, the traditional insurance providers of days of yore, actually went to medical savings accounts coupled with catastrophic care policies and it opened up a whole new market.

As far as companies that have offered medical savings accounts—I have heard it said there is no proof that they are going to work—virtually every case study of every company that has offered medical savings accounts has shown that health care inflation has been far less, with those companies than it has with traditional companies offering PPO and HMO coverage.

Mr. ENSIGN. Thank you.

And I would like to thank the Chairman also for holding these Committee hearings. I think that medical savings accounts are not going to be a panacea for our health care concerns, but they are certainly one of the answers to reforming our health care system. Thank you.

Chairman THOMAS. I thank the gentleman for his questions. The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman.

Let me thank all of our colleagues for their contributions to our work here in this Committee. I very much appreciate your testimony and your interest in health care issues.

I come to this issue from a similar perspective to you. The current Tax Code discriminates against medical savings accounts. An employer under our current Tax Code can set up a self-insured plan—which may be the most inefficient plan imaginable yet the Tax Code gives full tax preference to that type of plan. But, that employer cannot set up a medical savings account and get the same type of tax advantage. So I think we must, at least initially, remove that discriminatory practice which is currently in our Tax Code.

I worked with my friend Mr. Jacobs last year and Mr. Thomas to include the MSA provisions in the bill that we moved through this Committee last year, in the context of comprehensive health care reform. While we are not going to get comprehensive health care reform, that is clear, I think we need to work on a bill that will remove the discriminatory provisions and allow employers to have this option available to their employees with the same tax incentives as traditional insurance, and I look forward to working with my colleagues.

I do think, though, that we should look at the issue of risk selection; we should look at the administrative savings that we would like to be able to achieve; we should look at providing proper information to the consumer to make an intelligent choice and encourage preventive health care. These are issues that have been brought up that I hope that in our deliberations, as we move forward on legislation, that we listen to the concerns that have been

raised and, hopefully, develop an MSA bill that will be the best for all parties involved. I look forward to working with my colleagues in that regard, and I thank you for your testimony.

Chairman THOMAS. Thank the gentleman from Maryland. The gentleman from Texas.

Mr. JOHNSON. Thank you, Mr. Chairman.

Chairman Archer, I wonder if you could explain, maybe for the record, why we want a penalty tax included on withdrawals one and two. Is there any ultimate limit on what a savings plan can accrue?

Chairman ARCHER. We felt that if this savings account was going to be protected to be used for medical needs, that simply being able to withdraw at will was not a desirable thing to have.

We believe that it is very important that people should be encouraged to save and be able to accept personal responsibility to the greatest degree possible, and, therefore, we feel that it is appropriate to have a penalty for withdrawal for unauthorized purposes.

There is no limit to how much can be accumulated in the medical savings account.

Mr. JOHNSON. So over a 10-year period, it could go as high as $20,000 to $30,000 if they wanted to?

Chairman ARCHER. If you were fortunate to do a lot of good preventive maintenance and keep yourself in good shape, eat right and take care of yourself.

Mr. JOHNSON. Or found a good doctor like Ganske. Thank you, sir. I appreciate it. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The gentleman from California, Mr. Stark.

Mr. STARK. Well, as I say, I want to thank the panel. I think that there is evidence for a great deal of belief in free enterprise and thrift and shopping for medical care, and I only wish that that were sufficient to deal with the problem of the uninsured and the rising cost of medical care.

Unfortunately, the Joint Committee, in analyzing this, says it is assumed that this proposal would have a limited effect on the self-employed who currently do not have insurance; for individuals without insurance it would have a limited effect; for the low-income insured it would increase the tax benefits available to those individuals, but they are assumed to be insufficient to induce low-income individuals to purchase health care coverage. It does say, however, the bill for high-income uninsureds could provide an incentive to some high-income individuals who were perhaps voluntarily uninsured.

So, it does sound like it is a good bill for the rich who can use the tax deduction but will not do much, if anything, for 40 odd million Americans without health care coverage or for those who are attempting to have insurance in their own business. For the small business person who cannot get insurance, and for the low-income individuals in our country, it does not do much. For the high-income folks, it does let them buildup a tax exempt savings account with which they may have happier retirement years.

I look forward to the rest of the witnesses and appreciate our colleagues' contributions today. Thank you, Mr. Chairman.

Chairman THOMAS. Gentlewoman from Connecticut.

Mrs. JOHNSON OF CONNECTICUT. Chairman Archer, to clarify on the record, what kinds of expenses would be deductible under a medical savings account approach?

Chairman ARCHER. The normal medical expenses, which I believe that we have already clarified under the current law.

Mrs. JOHNSON OF CONNECTICUT. It is impressive that the medical savings account allows deductions for a lot more medical expenses than most insurance policies allow. You can deduct the cost of glasses, for example. The definition is in the Code. It defines the medical expenses that you can deduct over and above 7.5 percent of income.

But it will allow families to deduct prescription medications. It will not depend on whether you have a policy that covers prescriptions. It will allow you to deduct prescription medications, and I think dental visits, and vision care. So, it allows a far more comprehensive approach in support of health care benefits than any individual insurance plan, and I want to make that really clear on the record, because it provides an option that nothing else in the market provides.

I do want to commend my colleague, Mr. Roberts, because there are areas of the country in which managed care is not going to be the right answer. There are areas of the country where fee-for-service medicine is going to be the right answer. And as Mr. Ganske pointed out, fee-for-service medicine is perfectly capable of controlling costs if the incentives are right. This is the only legislative proposal out there that is going to assure that America will have the kind of high quality health care system that is appropriate in each area.

I do think this will mean that modernization of fee-for-service medicine will take place and it will survive in those areas where it ought to, and a family will have far more choices under this option than they have under any offer in the market now.

That is why it is such an important proposal, and I appreciate your work on it. I appreciate the depth of experience of this panel. We have never had a panel before us on this issue where there has been such depth of experience. This is a mature proposal in a way that it was not a few years ago, and I look forward to working with you to pass it and provide for the American people the same kind of choice that this week we are going to provide for seniors in America through Medicare Select.

Chairman THOMAS. I thank the gentlelady. If there are no other questions, I will thank the panel very much——

Mr. JACOBS. Mr. Chairman, could I make one observation for the record, take 30 seconds?

Chairman THOMAS. The gentleman from Indiana.

Mr. JACOBS. The old saying is that a rising tide lifts all boats. And the question has been raised about how in the world would this proposal help people who do not have insurance, people who are on Medicare, people who are not employed, self or otherwise?

And the answer is that a falling tide lowers all prices, if you think about it. If you have millions of people in this country employed, exercising discretion and prudence in shopping, the prices do not simply fall for them, they fall for the entire economy and

thereby inure to the benefit of the Medicare Program and the Medicaid Program and the unemployed generally.

Chairman THOMAS. If you will hang on for just a moment, I believe the spirit has moved the gentleman from Washington.

Mr. MCDERMOTT. Mr. Chairman, thank you. I just wanted to ask a question. Many of the people on the panel are advocates of changing the tax structure to some kind of flat tax or something. Can you tell me how this would work in relationship to a flat tax system?

Chairman ARCHER. With a flat tax, you would still have—you would still have, I assume, although I do not know what flat tax proposal you are looking at, it is one thing to talk about a flat tax, it is another thing to analyze all of the details of it, but it is very possible that it could still have the same tax deductibility consequences under a flat tax, depending on how it is arranged.

If you go to taxing goods and services, which I would like to do, then you do not have to worry about tax deductions for anything because you are not taxing income in any way, shape, or form. So, there is no need to be concerned about how the income tax law will apply to these sorts of programs.

Mr. MCDERMOTT. So, you are really saying that you think that under a flat tax you would still have tax deductibility of health insurance.

Chairman ARCHER. Depending on—I am not the advocate of the flat tax in this Congress, but depending on the actual formulation of the flat tax, it is very possible that you could.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Once again, I want to thank the panel.

The Chair would request that the next panel consisting of Mr. Hustead, Mr. Hendee, and Mr. Goodman please come forward. The Chair would inform each of the members if you have a written statement it will be made a part of the record without objection and you may proceed to inform the Subcommittee in any way you see fit in the time afforded to you.

Mr. Hustead.

STATEMENT OF EDWIN C. HUSTEAD, SENIOR VICE PRESIDENT, HAY/HUGGINS, ON BEHALF OF AMERICAN ACADEMY OF ACTUARIES MEDICAL SAVINGS ACCOUNT WORK GROUP

Mr. HUSTEAD. Thank you, Mr. Chairman.

My name is Edwin Hustead. I am the chair of the American Academy of Actuaries' work group on medical savings accounts and also a senior vice president with the Hay/Huggins actuarial consulting firm.

We have prepared a general report on medical savings accounts, which was delivered in May and hopefully has been of some use, and are now proceeding to a report and a study specifically on H.R. 1818 and other proposals.

I think it is helpful, when you think in terms of a medical savings account and a high-deductible deductible plan and their effect, to think of three steps in the process: First, there would be the enabling legislation, such as H.R. 1818; second, employers and insur-

ers would then redesign their programs and their benefits packages to take advantage of the option that would be offered by a high-deductible plan and an MSA; and, third, this offering would then be provided to the employees and the employees would choose the plan they want.

To just talk briefly on those three steps, and our written testimony is there for the record, the legislation, to the extent that I have had a chance to look at it, seems well-designed to deal with the setting up and enabling legislation for a high-deductible MSA option for employers and insurers. It deals successfully with the problems we have pointed out, such as the interaction of two policies for two family members.

One technical issue that I would raise, at least in my reading of the bill, suggests that a family would have to meet a $3,600 deductible in order to be able to set up an MSA, whereas an individual would only have to meet an $1,800 deductible. If I am reading that correctly, that means an individual in a family would have to meet more of an increase in deductible than an individual in their own policy. You may want to look at that provision.

Most of what would go on in a high-deductible/MSA introduction would deal with the employer response. Now, the assumption of the work group is that the employers would want to keep their health care costs constant, so the employers will then want to redesign their health plan to accommodate high-deductible MSA options, and in our report we show what would happen if an employer were to introduce a high-deductible plan.

For example, if an employer were to go from a $200 deductible plan to a $2,000 deductible plan, they could save an average of $828 per person. That would be the amount they could put in a medical savings account and keep their costs constant.

But there are two cautions, in reference to the employer design. First, if an employer were to keep other options in their program, then it is likely that the healthiest individuals would go to a high-deductible plan and the savings would be less than the figures we show in our report. Second, if the employee who had a medical savings account were to consider that MSA as just another form of insurance, then the cost savings could be lower than had been predicted in our report. So, we would suggest to employers they view those two aspects.

Another thing that employers will have to consider as they redesign their plans will be how to deal with current management approaches, the health maintenance organizations, the point-of-service plans, and so forth. Employers have been very successful and done quite a bit with managed care organizations to control cost in recent years. Presumably, they will want to add to those savings that they have already achieved through introduction of a high-deductible plan.

And finally, an employer or insurer is going to have quite a communication process, as they relate these plans to the individuals. Employers are used to having successful communication programs and we think that they can achieve that to tell employees what they really have and how these new plans work.

As far as the result on the individuals, we show in the report, and I show in the testimony that, on average, individuals will gain

from this new system. There will be 25 percent of employees and individuals who do not meet the current deductible. If an employer gave them $700 or $800, that would be a net gain. There would be, as has been pointed out so far already, the employees and individuals with very high medical expenses with a net loss. In the example we give, the loss could be $1,200 per person per year with high medical expenses. We figure that about 8 percent of the employees would be in that category.

As far as overall savings, if you take an average group and move them from a current fee-for-service nonmanaged plan to a high-deductible plan, administrative savings would be substantial. We figure about 20 percent of the administrative costs would be saved, claims costs would be saved. There would be savings up to 10 percent of the total cost, again depending on how the individual viewed their MSA.

Thank you very much.

[The prepared statement and attachment follow.]

[Medical Savings Accounts Cost Implications and Design Issues attachment is being held in the Subcommittee's files.]

STATEMENT OF EDWIN C. HUSTEAD, HAY/HUGGINS, ON BEHALF OF AMERICAN ACADEMY OF ACTUARIES MEDICAL SAVINGS ACCOUNT WORK GROUP

INTRODUCTION

Thank you for the opportunity to address the subcommittee today on the subject of medical savings accounts (MSAs) and, specifically, on H.R. 1818, the "Family Medical Savings and Investment Act of 1995." I am Edwin Hustead, the chairperson of the American Academy of Actuaries' Medical Savings Accounts Work Group and a Senior Vice President with the Hay/Huggins division of the Hay Group. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries.

Briefly, H.R. 1818 would enable employers and their individual employees to establish MSAs. The bill stipulates that the only insurance coverage required would be a catastrophic health insurance plan with a deductible of at least $1,800 a year. The employer or individual could contribute a given amount, on a tax-deferred basis, to the MSA. This amount could be no greater than the lesser of the deductible or $2,500 a year.

MEDICAL SAVINGS ACCOUNTS

An MSA is an individual medical account that employees can draw from to pay for their ongoing medical expenses. It is set up by an employer for an employee who is eligible for health insurance coverage, and funded by employer and/or employee contributions. The concept of MSAs has generated tremendous interest this year, largely because some believe that, if MSAs were to become popular, they would provide sufficiently powerful incentives to covered individuals to motivate them to play a more active role in making responsible decisions on how their medical care dollars are spent. However, others are concerned that MSAs might neutralize the utilization controls already in place in managed care plans, and place an increased financial burden on the very individuals who are most in need of health care services.

The Academy Medical Savings Accounts Work Group's May 1995 report, "Medical Savings Accounts: Cost Implications and Design Issues," presents actuarial analysis and commentary on the MSA concept.

Employer Contributions for Health Care

Table 1 shows the work group's estimates of the approximate cost of insurance plans with various deductible and maximum out-of-pocket limits. If, for example, an employer were to replace a $200 deductible plan with a $2,000 deductible plan, the premium for the average employee would decrease by $828. This illustration assumes that the $200 deductible plan would have a $1,000 maximum limit on out-of-pocket expenses and that the $2,000 plan would have a $3,000 limit. It also assumes that the plan would cover a typical work force and that all employees would participate in the plan.

Table 1
Cost of Different Copayment Designs- Individual Plan

Deductible/ Maximum Out-of-Pocket	Premium	Reduction from Baseline Premium
Baseline		
$200/$1,000	$2,699	-0-
$1,000/$2,000	2,176	523
$1,500/$2,500	1,996	703
$2,000/$3,000	**1,871**	**828**
$3,000/$4,000	1,666	1,033
$4,000/$5,000	1,501	1,198
$5,000/$6,000	1,369	1,330

Source: American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*. Public Policy Monograph No. 1, May 1995.

Note: Relative cost of plans after consideration of induction, before consideration of the MSA.

What causes this reduction in premium? Raising the deductibles and out-of-pocket limits reduces the portion of the bill paid for by insurance, inducing employees—now responsible for paying a larger share of their health care costs—to use less health care services. This effect, termed "induction" by the work group, may work so as to bring the consumer into the health care arena as an active payer.

The work group assumes that employers will probably try to hold their health expenditures constant with the introduction of the MSA and high-deductible plan. The employer could keep the total health care expense at $2,699 per person by putting the $828 in premium savings into an MSA (Table 1). The total employer cost, $1,871 for the high-deductible plan and the $828 to the MSA, would equal the cost of the low-deductible plan costing $2,699.

Factors Affecting Premium Savings

There are at least two aspects of MSAs that could reduce the premium savings employers would otherwise enjoy by purchasing a less expensive high-deductible plan, and therefore, the amount that an employer would be willing to contribute to an MSA. First, if employees consider their MSA balance as little more than another form of insurance, then much of the savings from induction would be lost. Consider, for example, a $500 health care expense. The current low-deductible plan would pay $240 of the current cost, with the individual responsible for the remaining $260 of the $500 expense (Figure 1). The MSA/high-deductible, in contrast, would pay none of the cost (Figure 1).

Figure 1
$500 Health Care Bill

Low-Deductible Plan	MSA/High-Deductible Plan
Plan Pays $240	Plan Pays $0
Calculations	
$500 cost	
- $200 deductible	
= $300	
$300	
x 80% coinsurance	
= Plan payment of $240	

Possibly, the $260 out-of-pocket expense of the employee enrolled in the low-deductible plan could encourage him/her to use less health care services. On the other hand, the employee with an MSA balance of at least $500, which he/she views simply as another form of insurance—not part of personal savings—may actually be encouraged to use more health care, because he/she would assume that their out-of-pocket expenditures had actually decreased by $260.

Second, if an employer offers the MSA/high-deductible plan within a benefit program that includes other options for health insurance coverage, the healthiest people would tend to select the high-deductible plan; the less healthy people would most likely continue using the low-deductible plan. Since health care costs for the employees who opt for the high-deductible plan would be lower than average, the premium savings from moving to a high-deductible plan would also be lower than is shown in the Table 1.

Another factor that could affect how much money is actually saved is the interaction between the MSA/high-deductible plan and managed care. If H.R. 1818 were enacted, employers would need to review their health benefits programs to determine how to integrate the MSA option with their current benefit plans. One concern employers have mentioned is the interaction between an MSA/high-deductible plan and current managed care plans, such as health maintenance organizations. Employers have expended a great deal of effort in applying strict management to their health insurance programs to maximize savings, with recent trends in health premiums suggesting that much of this effort has been successful. Some of these savings could be lost if the MSA/high-deductible plan were to attract significant numbers of enrollees.

Impact on Employees

The work group's analysis shows that, on average, employees would benefit financially from

enrollment in an MSA/high-deductible plan. However, employees with a large medical expense, such as $25,000, who are enrolled in an MSA/ high-deductible plan would pay $2,000 more out-of-pocket for covered health expenses than the individuals covered under a low-deductible plan. The net loss to these employees, after application of the $828 MSA contribution, would be $1,172 (Figure 2). The work group's analysis showed that approximately 8% of the insured population would face the full $1,172 increase in out-of-pocket expenses.

Figure 2
$25,000 Health Care Bill

Low-Deductible Plan	MSA/High-Deductible Plan	Difference Between Plans
Enrollee pays $1,000	Enrollee pays $2,172	$1,172
	Calculations	
$1,000 maximum-out-of-pocket limit	$3,000 maximum-out-of pocket limit - $828 MSA contribution = $2,172	$2,172 - $1,000 = $1,172

It is important to determine which health care expenses will be covered by the high-deductible plan and those that can be paid from the MSA. Employees could be permitted to spend their MSA funds on items not generally covered under the health plan. For example, an employee might spend $2,000 for permitted MSA expenses that include $500 of services not allowable under the MSA/high-deductible plan. Having spent $2,000, an employee who had to be admitted to a hospital might presume that he was only responsible for 20% of remaining charges up to the $3,000 maximum out-of-pocket limit. However, the insurer would review the $2,000 in expenditures and determine that the employee would, in fact, have to pay the first $500 of the hospital bill before the insurance protection begins.

Effect of Health Care Costs

The work group's analysis found that the replacement of a low-deductible fee-for-service plan with an MSA/high-deductible plan would result in lower health care expenditures for a typical group of employees. In addition, administrative expenses would decrease by approximately 20%. Health care costs for this typical group of employees would decrease by up to 10%, depending on the extent to which the employees considered the funds in the MSA to be personal savings, rather than insurance.

CONCLUSION

The concerns noted above about the effects of H.R. 1818 emphasize that employers will need to give some thought to redesigning their overall health benefits programs to incorporate an MSA/high-deductible plan. This new kind of plan could be a valuable new option for employees. However, to integrate the new MSA/high-deductible plan successfully, employers will need to design them carefully and get accurate estimates of their probable cost. In addition, employers will need to communicate effectively with their employees about how the new plan works.

The work group has not yet completed its analysis of H.R. 1818. One important point to note at this time, however, is that the $3,600 lower limit on the deductible for a family plan may be overly burdensome. Most employer plans currently provide a deductible per individual family member—often with a maximum on the total deductibles for a family. The individual deductible is usually the same as the deductible for a single-person plan. If the family plan requirement of $3,600 is read as a minimum expenditure that the family must meet, then the increase in out-of-pocket expenses will be much greater for a family than for an individual.

The Academy work group is available to answer additional questions.

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ISSUE BRIEF
AMERICAN ACADEMY OF ACTUARIES

Medical Savings Accounts

The efficacy of medical savings accounts will be determined, in large part, by their plan design. However, young and healthy employees could be big winners with an MSA. Depending upon plan design, approximately two-thirds of current workers would gain financially if employers combined MSAs with high-deductible plans.

In an American Academy of Actuaries study, the 17 percent of employees who have no medical expenses reimbursed by their current health plan would have the highest gain—possibly more than $600 under an illustrative plan examined by the Academy. The 8 percent of employees who have high medical expenses would have the greatest loss—as much as $900 under the same plan. Administrative costs, which now account for approximately 15 percent of claims payments, also would be considerably lower under MSAs.

This brief is based on the full report, "Medical Savings Accounts: Cost Implications and Design Issues," which is available from the American Academy of Actuaries.

1. Introduction: What Is an MSA?

A medical savings account (MSA), as envisioned in most current proposals, is an individual medical account that employees can draw from to pay medical expenses. It is set up by an employer for an employee who is eligible for health insurance coverage and is funded by employer and/or employee contributions.

Funds in the MSA would be designated as the employee's own money. Any portion of the fund that is not used to pay for current medical expenses can simply accumulate in the MSA. There it is allowed to earn interest and will be available for any future medical expenses.

Funds in an MSA usually would not be sufficient to cover the cost of major illness. So MSAs will almost always be combined with a health insurance plan that covers medical expenses above a fairly high deductible.

Deductibles that have been discussed range from $1,000 to as high as $3,000. Above the deductible, the catastrophic insurance plan might also have some co-insurance, say 20% of all medical expenses up to $5,000. Amounts in the MSA could be used to pay expenses up to the deductible and copayments above the deductible, provided the MSA had sufficient funds.

As a general rule, MSA funds would come from annual tax-free contributions made by the employer to each employee's account. Initially, the employer would probably contribute an amount equal to the difference between the per-employee cost of the high-deductible insurance and the per-employee cost of the employer's lower-deductible plan. If the combined MSA/high-deductible plan generated further future savings, the employer might or might not choose to pass the savings on to workers through higher MSA contributions.

Because MSAs cannot be established under current law, there are many theories about how MSAs might

The American Academy of Actuaries is the public policy voice of the actuarial profession, providing the actuarial profession's expertise to policy makers. This issue brief is taken from a monograph on medical savings accounts produced by the Academy's Medical Savings Account Work Group, Edwin Hustead, chairperson. Other members of the group are Peter Hendee, Roland E. (Guy) King, Mark Litow, Gerald R. Shea, Harry L. Sutton Jr., and George B. Wagoner Jr.

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affect the U.S. health care system. Employers, employees, health care providers, and the IRS all would be affected. Determining their preferences is critical to predicting how MSAs would affect U.S. health care.

2. Effect of the High Deductible

The high-deductible component of the MSA/high-deductible coverage will have one very important feature. It will include copayments from the patient (such as deductibles or co-insurance) substantially higher than those typical in today's health insurance market. This could exert a potent effect on how MSA owners decide to spend their MSA funds.

Available research indicates that the demand for traditional health care depends to a considerable extent on how much of a provider's bill must be paid out of one's own pocket. In 1978, when Newhouse et al. investigated the two extremes, total coverage and no coverage, individuals with full coverage of medical expenses made twice as many physician visits as those without coverage.

Copayments exert two significant effects. Higher copayments cause a decrease in insured health care expenses because less of each medical bill is paid by the insurer. Also, having to pay more out of one's own pocket discourages people from using health care services.

How will employees think about their MSAs? If they think of them as little more than another type of insurance, then utilization might be much the same as with a typical low-deductible plan. In some cases, utilization might actually be greater. By contrast, if employees consider their MSAs to be personal savings accounts, utilization might be depressed to almost the same level as a high-deductible policy without an MSA.

If workers look upon their MSA as savings, potentially countervailing motivations would arise. Having control of how health care dollars are spent, through an MSA, could make individuals smarter shoppers for medical care.

On the other hand, insurers generally place limits on what they will reimburse. Without these limits, MSA funds will be available for more services than plans currently cover. In many proposals, all the services recognized by the IRS as legal for income-tax-deduction purposes are considered appropriate for MSA expenditures. Services for routine physicals, eyeglasses, psychological consultations, and cosmetic services are often excluded or limited.

Other plan design elements can also modify the cost-deterring impact of a high deductible. These include limitations on cost-sharing like out-of-pocket maximums. Also, provisions stipulating whether deductibles include or exclude certain kinds of services can alter the effect of the deductible.

Further, the amount of new savings possible from adding a high deductible depends greatly on how much cost savings has already been achieved by the plan that preceded the new high-deductible plan. Perhaps the old plan, through tightly managed control, such as in an HMO, has already eliminated most of the excess utilization. Then, the high deductible will likely not yield very much in further savings. Hospital costs, in particular, may not be susceptible to further savings. Data show that utilization has already dropped by 25% in the last 10 years. There will, however, be more room for savings in other areas such as drugs, outpatient care, and professional services.

Conclusion. The extent to which MSAs will generate savings is far from certain. When consumers are offered only catastrophic coverage through high-deductible plans, health care spending falls. However, when MSAs which work so as to offset the high deductible are introduced, health care spending may or may not fall, depending on a number of factors. Spending could decrease if the law governing MSAs is well-conceived, if employers design their MSA options carefully, and if workers eventually view their MSAs as their own personal savings.

3. Tax Treatment of MSAs

It will be critical, in promoting the widespread introduction of MSAs and ensuring that they are financially sound, to establish a well-thought-out roster of tax regulations to foster these objectives.

Under most MSA proposals, both contributions to MSAs and payments for health expenses from MSAs would come from before-tax monies. However, employees would have to pay taxes if they used their MSA funds for nonmedical purchases, in addition to a penalty if the money was taken out before some specified age.

Right now, health care expenses paid by employers are fully tax deductible. Current proposals stipulate that all contributions to MSAs would be tax deductible as well. However, some specify that an employer's total tax deduction for the new MSA/high-deductible plan would be limited to what

the employer pays in insurance premiums for the current health care plan.

There are substantial differences among proposals concerning the tax treatment of the investment income that would accumulate on unspent MSA funds. Some proposals would tax the interest earnings on MSA account dollars. Others would allow investment earnings to accumulate tax free.

Proposals also differ in regard to how much money could accumulate in an MSA. And there are differences in what is specified as appropriate nonmedical circumstances for making withdrawals from the MSAs.

Conclusion. If either contributions to or medical withdrawals from MSAs were taxed, there would be no particular advantage to having one. Few employees would want an MSA, and few employers would establish them. On the other hand, if there are no limits on pre-tax contributions and the tax-free buildup of funds, MSAs would lead to greater government subsidization of health care and lost tax revenues. MSAs could then become a tax shelter for the well-to-do and a tax-free vehicle for special-purpose savings (e.g., down payments on first homes). The tax treatment of MSAs must be skillfully crafted to encourage their adoption, while discouraging their use as mere tax-planning devices.

4. Administrative Expenses

Currently, administrative expenses for all the insured plans in the United States average 15% of claims payments. MSAs could reduce some of this expense. Employees would have direct access to the funds in their MSA account, so they would not need to file any claims.

However, the administrative costs of the high-deductible component must be considered, too. With a standard (low) deductible plan, there are many low-cost claims. For these, administrative expenses represent a high percentage of the claim payments. The low-cost claims are avoided with a high-deductible plan. But insurers will absorb considerable expense in managing the complex cases under the high-deductible plan. For example, a $2,100 claim with a $2,000 deductible in place will be expensive to administer. The insured amount is only $100, but the entire $2,100 of expenses must be verified as covered expenses.

For the MSAs themselves, however, administrative costs will probably be much lower than with a standard low-deductible plan. In fact, if MSAs are not subject to expenses like premium taxes, sales commissions, or extensive reporting for tax purposes, administrative expenses could be as low as 2%.

Conclusion. Administrative expenses, which now account for approximately 15% of claims payments, would be about the same for high-deductible replacement plans. There would be overall administrative cost savings, however, because there would be fewer claims to process. The administrative expenses for MSAs would be lower than the expenses for other types of health insurance. Thus, for a combined MSA/high-deductible plan, administrative costs will be less than the current 15%.

5. Health Plan Options

Adverse selection is one possible consequence of employers offering MSAs as one of a range of health coverage options for their employees.

Roughly defined, adverse selection results when individuals attempt to figure out, and then opt for, the insurance coverage that provides them with the greatest financial benefit. Presented with a range of health plans, the healthier people would tend to pick the high-deductible, low-cost plan. The less healthy would usually choose a low-copayment plan. The effects of this selection process are increased premiums for the low-copayment plans and corresponding decreases in premiums for the high-deductible plans.

But even more problematic is the case in which the MSA is offered alongside other plans whose fundamental philosophy and design differ dramatically from that of the MSA—managed care plans.

The current environment is built around a system of management controls and discounts. The extreme approach, traditional HMOs, combines both of these. Integrating the MSA concept into this environment presents significant problems. The goal of the government and employer should be to preserve the savings achieved by the current environment while offering the employee more influence in the purchase of health care.

The simplest solution for employers would be to offer the managed care plan as a totally separate option. It would be possible, but difficult, to integrate managed care into the framework of the MSA itself. The latter approach would require a major restructuring of the copayment and reimbursement structure of the traditional HMO. State and federal law would have to be modified to permit HMOs to compete within this changed environment.

Conclusion. Employers, insurers, and providers have built a complex web of management controls and discounts that have already squeezed much of the savings out of the health care industry. Most of these programs offer several ways for the employee to opt out of the highly managed care but with control mechanisms that overcome the effect of adverse selection. The major problem for employers and insurers will be to expand and restructure their programs to fold in an MSA/high deductible option without losing the savings already achieved by the current program.

6. Effects on Health Care Costs

To estimate what savings (or losses) might be anticipated from the new MSA/high-deductible plans, three actuarial assumptions are needed. These are (1) the distribution of health care expenditures under current plans; (2) the change in utilization and cost that would ensue from the higher copayments of the high-deductible components; and (3) the extent to which the availability of an MSA fund would offset the savings from high deductibles.

The work group compiled the best available data on how health dollars are spent today. The group selected a range of factors used in predicting how much utilization and cost might decline when copayments increase. This information was employed to determine the consequences of substituting a new MSA/high-deductible plan for a fee-for-service plan that has little or no management of care.

The new MSA's effect could range, on average, from almost full offset of the expected dampening impact of a higher copayment to little impact at all. The key is the employees' perception of their MSAs. Do they think of their MSAs as their own personal savings which must be conserved for medical emergencies? Or do they view their MSA as merely additional insurance money to spend as they like on health care? It is this spectrum of differences in how employees would view their MSAs that requires the use of ranges in the estimates below.

Bearing this in mind, we can anticipate the impact of increasing a deductible for an individual from $200 to $1,500. Co-insurance above the deductible is 20%. Then, total expenditures for health care costs would decrease from $3,041 per employee to a range of $2,695 to $2,976.

Also, the premium for the health plan would drop by a range of $585 to $690. Assuming that the employer holds constant how much it spends for its employees' health care, this is the amount that the employer would pay into each employee's MSA.

The *average worker's* out-of-pocket expenditures would fall from $882 to a range of $536 to $817. However, the range of out-of-pocket charges for *individual workers* would be much greater.

The largest average savings for the 17% of employees who have no medical expenses reimbursed by their current health plan would be $574 to $676. This money would actually accrue for those workers, personally, in their MSA accounts.

At the other end of the spectrum, the largest cost increase would be experienced by the 8% of employees who have high medical expenses. They could see an average increase in their cost ranging from $827 to $926. And an individual worker could have a much higher increase than the average. These are their incurred out-of-pocket expenses that would be added to the out-of-pocket expenses under their old plan, less the employer MSA contribution.

These numbers are predicated on two assumptions. First, all employees are covered by the MSA, so there is no adverse selection. Second, managed care in the current plan is minimal. Under this scenario, roughly two-thirds of all employees would stand to gain financially by the introduction of MSAs. The other one-third would lose, because less of their high medical costs would be covered.

Conclusion. It is reasonable to expect some savings in health care expenses from the introduction of MSAs. However, that expectation is predicated on a favorable outcome with a long list of factors. Some of these factors will be within the control of the individual company (plan design features). But others (notably, tax treatment) are external to the company.

Therefore, achieving the greatest possible savings via MSAs will require well-designed legislation. It will also rest upon careful planning on the part of those employers that decide to establish health care plans with MSAs. Finally, the savings will depend on the extent to which individuals believe they have some stake in spending their MSA dollars wisely, along with their ability to become more sophisticated, cost-conscious health care shoppers.

Mr. CHRISTENSEN [presiding]. Mr. Hendee.

STATEMENT OF PETER G. HENDEE, CONSULTING ACTUARY, ODELL & ASSOCIATES, INC., WINSTON-SALEM, NORTH CAROLINA

Mr. HENDEE. Mr. Chairman, thank you for this opportunity to testify regarding the Family Medical Savings and Investment Act of 1995.

My name is Peter Hendee. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I am here as a consulting actuary who practices in the health care financing market.

This bill will encourage the use of a promising health care financing mechanism. It will eliminate the handicap imposed in the current tax law on health care savings by giving savings the same tax treatment now reserved for health care spending. This will make it practical for employers to provide medical savings accounts for their employees.

Not only will medical savings accounts be put on a level playingfield with other mechanisms for employee health care, the bill also counters the current tax law's bias against the self-employed and individuals who purchase their own health insurance. These people will continue to be at a tax disadvantage for the catastrophic portion of their health care financing, but their medical savings accounts will be treated on a consistent basis with employer-provided health care.

I would like to address a couple of provisions of the bill. The distribution rules are reasonable and they are not too onerous. The taxes on distributions that are not used for health care are significant enough to encourage responsible behavior. But very importantly, they are not excessive; the accountholder will feel that money is available for a nonhealth care need if it arises, and this is necessary for the accountholder to have an incentive to be a careful purchaser of health care.

The bill also includes an automatic inflation adjustment for the minimum catastrophic deductible, and that will make sure that this critical plan feature receives the periodic attention it needs. It needs attention because over time the rising cost of medical care can make current deductibles less significant and that will weaken the individual's incentive to control health care spending.

One concern I have with the bill is that mandated insurance benefits, such as first dollar coverage for certain preventive services, are required by some States. As a result, in those States it may not be legal to issue health insurance coverage that meets the proposed definition of a catastrophic health plan. So, under this bill, citizens of those States could not buy a catastrophic policy and set up a medical savings account.

I do have two possible solutions for your consideration. The first is to preempt the mandated benefit requirements, at least for catastrophic products to be used with medical savings accounts. And an alternative is to expand the definition of "permitted coverage" in this bill to include those mandated benefits.

Many States have enacted medical savings account legislation, many others are considering it, but the unfavorable Federal income

tax treatment is a forceful impediment to the widespread use of this popular free market health care reform.

I am pleased to be here today to support the same tax treatment for health care savings as for health care spending, and I will be happy to take your questions.

[The prepared statement follows:]

Testimony of

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on H.R. 1818
The Family Medical Savings and Investment Act of 1995

before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives

June 27, 1995

Mr. Chairman, thank you for this opportunity to testify regarding the Family Medical Savings and Investment Act of 1995 (H.R. 1818).

My name is Peter Hendee and I am a Member of the American Academy of Actuaries, a Fellow of the Society of Actuaries and a Fellow of the Conference of Consulting Actuaries. I am here as a consulting actuary who practices in the health care financing market.

Enacting this bill into law will encourage the use of a promising health care financing mechanism. It will eliminate the handicap imposed by current tax law on health care saving by giving saving the same tax treatment now reserved for health care spending. This will make it practical for employers to provide these accounts for their employees.

These accounts enable individuals to make their own health care purchasing decisions and to accumulate the funds that they do not spend. This makes the patient a buyer as well as a user of health care and provides an incentive to seek cost effective quality health care. It will restore free market characteristics to the provision of health care.

Authority over health care spending is given to the patient instead of imposing third party controls on the patient. This reduces third party intrusion into the provider-patient relationship.

Not only will medical savings accounts be put on a level playing field with other mechanisms for providing employee health care, the bill also counters the current tax law's bias against the self-employed and individuals who purchase their own health insurance. Although these people will continue to be at a tax disadvantage for the catastrophic insurance portion of their health care financing, their medical savings accounts will be treated on a consistent basis with employer provided health care. They will not have to fund these accounts with after tax dollars.

Distributions

The proposed distribution rules are responsible but are not onerous. Taxes on distributions not used for health care are significant enough to encourage responsible behavior. Very importantly, they are not excessive; the account holder will feel the money is available for an important need. This is necessary for the account holder to have an incentive to be a careful purchaser of health care.

Inflation

This bill includes an automatic inflation adjustment for the minimum catastrophic deductible. This provision will make sure that this critical plan feature receives the periodic attention it

needs.

As the cost of medical care rises, deductible levels that are catastrophic today will, over time, be reached by an increasing portion of individuals and families. Periodic updating of the deductible is necessary for the long term success of these plans. The catastrophic deductible must not be allowed to become irrelevant, such as a $50 deductible is today. If it becomes immaterial, then the individual's incentive to control health care spending is weakened.

Administrative Expenses

Filing and processing claims has a cost for patients, for health care providers, and for insurance companies. Small expenses, particularly for routine services, are better handled by the patient paying for them directly.

The majority of people will not exceed their catastrophic deductible amount in a year. These people can pay for all of their health care directly. This eliminates the need to process detailed information on their health care spending.

State Laws

Mandated insurance benefits, such as first dollar coverage for certain preventive services, are required by some states. For example, Florida Insurance Law Section 627.6579 specifies a schedule of physician services for children that must be covered, exempt from any deductible, under all group insurance policies that provide expense-incurred family coverage. As a result of these laws, in some states it may not be legal to issue health insurance coverage that meets the proposed definition of a "catastrophic health plan."

One possible solution is to preempt state mandated benefits, at least for catastrophic products to be used in conjunction with medical savings accounts. Another possible solution is to expand the definition of "permitted coverage" in H.R. 1818 to include mandated benefits.

Conclusion

Many states have enacted medical savings account legislation and many other states are considering such action. Unfavorable federal tax treatment, however, is a forceful impediment to widespread use of this increasingly popular free market health care reform.

I am pleased to be here today to support the same tax treatment for health care saving and health care spending. I will be happy to take your questions.

Mr. CHRISTENSEN. Thank you, Mr. Hendee.

Dr. Goodman, the Committee would be pleased to hear your testimony.

STATEMENT OF JOHN C. GOODMAN, PH.D., PRESIDENT, NATIONAL CENTER FOR POLICY ANALYSIS

Mr. GOODMAN. Thank you, Mr. Chairman.

My name is John Goodman. I am president of the National Center for Policy Analysis.

Mr. Chairman, I would like to begin by saying that I believe the traditional fee-for-service health insurance policies that we have, most of us have grown up with, cannot survive in the marketplace. A policy that allows you to see any doctor you want to see, select any test you want to have, while sending the bill to someone else, I think simply cannot, will not, be affordable for most Americans. Therefore, what is happening in the marketplace right now is that people are exercising one of two options. Either they are going into managed care programs where their choice of physician is restricted and where there are limits on the kinds of tests they can have access to, or, if they want to make many of those decisions for themselves, then they have to agree to manage some of their own health care dollars.

Of course, one of the ways to allow them to manage their own health care dollars is through medical savings accounts. We presented this option to our own employees and the answer was unanimous, they opted for the medical savings account. This chart to my right shows how we designed it for the employees with families who work for the NCPA.

We have a deductible for the families of $2,000, and we make a deposit to the medical savings account of $1,500. So, when our employee is going to the medical marketplace, the first $1,500 they spend from their medical savings account. The next $500 they spend out-of-pocket, and when they reach the $2,000 deductible the plan covers all expenses above that.

Now, if we can look at the next chart I think I can answer Mr. Stark's question, at least for employees who work for us. In the left-hand column you see our previous year's policy.

Mr. CARDIN. Excuse me, is this in our written material because I personally cannot see those numbers. Maybe I need new prescriptions. Can that be moved forward?

Mr. GOODMAN. It is in the material. It is in my testimony, yes.

Mr. CARDIN. Thank you.

Mr. GOODMAN. Last year, suppose we have an employee with a child who had cancer, and that family knows they will hit the maximum on their deductible and copayment.

Well, the deductible last year was $500 and we had a 20-percent copayment for another $1,000. With this sick child, that family would have spent $1,500 in out-of-pocket expenses. This year, for no extra cost to us, by the way, we moved to the medical savings account plan, and now as you can see, the most this family will pay out-of-pocket is $500. So, for the family with the sick child, it is as though the switch of plans resulted in a $1,000 raise for that family. We have reduced by $1,000 the cost to them of medical care for that child.

Now, not all employers may choose to design their plan the way that we have, but of the plans I have looked at in the marketplace, most of them have this type of design. In other words, if you look carefully at choices people are exercising, you will find that in most cases sick people gain by choosing the medical savings account alternative.

I would also like to address one other criticism that has been made this morning, and that is the idea that medical savings accounts interfere with managed care. The fact of the matter is they really do not. At the NCPA, we have to decide when our employees have actually met the $2,000 deductible before the plan starts paying for all medical expenses. As it turns out, we count all of their expenses as long as they stay in a network that has been selected for us by the insurer. If the employees go outside the network, which they can, then we only pay 75 percent of the usual and customary fees.

What we have is essentially a network, a point-of-service plan that is very common in managed care plans around the country, but we also have a medical savings account. What we have done is we have integrated the medical savings account with managed care. We think, in this way, we get the advantages of both.

The problem, Mr. Chairman, that several others have pointed out this morning, is the tax law. The tax law discriminates against this kind of plan. It subsidizes other kinds of plans. What we ask for is a level playingfield. Let us let the market decide what the right kind of plan is. Let us not do so legislatively.

Thank you.

[The prepared statement follows:]

Medical Savings Accounts and the Future of Health Care

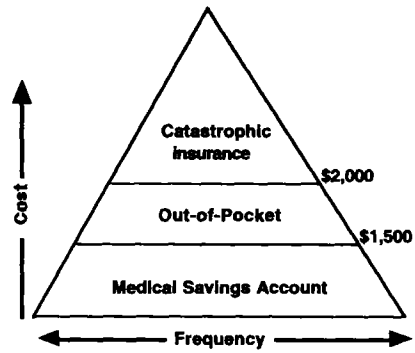
John C. Goodman, Ph.D.
President, National Center for Policy Analysis

The traditional, fee-for-service health insurance policy — that lets people choose their own doctor or select any diagnostic test and send the bill to someone else — is being priced out of the market. Most people can no longer afford it. As a result, most people will have to settle for one of two options: (1) either they will enroll in a health maintenance organization (HMO) that restricts their choice of physicians and limits their access to medical services; or (2) if they want to make these choices for themselves they will have to manage their own health care dollars through Medical Savings Accounts (MSAs).

Currently, the Internal Revenue Service taxes MSA deposits, although employer payments for third-party insurance are tax free. The Archer-Jacobs "Family Medical Savings and Investment Act" (HR 1818) would end this discriminatory treatment.

How Medical Savings Accounts Work. Medical Savings Accounts give people the opportunity to move from a conventional, low-deductible health insurance plan to one with a high deductible (say $2,000 to $3,000) and to put the premium savings in a personal savings account. These accounts are used to pay for routine and preventive medical care, and are combined with a high-deductible health insurance policy that pays for major expenses. Employees and their families pay all medical bills up to the deductible from their MSAs and out-of-pocket funds. Catastrophic insurance pays all expenses above the deductible.

FIGURE I



Employers and their employees are turning to MSAs for the same reason others are turning to managed care: to control rising health care costs. Since employees get to keep any MSA money they do not spend, they have a financial incentive to shop prudently in the medical marketplace. In general, they won't spend a dollar on health care unless they get a dollar's worth of value. Employer experiences with MSA plans show that the incentives work: employees curtail health care spending significantly.

The NCPA's Employee Health Plan. In 1994 the employees of the National Center for Policy Analysis had a conventional fee-for-service health plan with a $500 deductible and a 20 percent copayment. Under this policy, an employee was at risk for up to $1,500 out of pocket. If three members of the same family all became seriously ill, the family was at risk for $4,500 in medical bills.

This year the NCPA adopted an MSA plan that limits the exposure of the employees and at the same time gives them more control over their health care dollars. *At no extra cost to the employer*, the plan creates a $1,500 deductible and deposits $1,125 to an MSA for individual employees. For family coverage, the deductible is $2,000 and the MSA deposit

is $1,500. [See Figure I]. The total out-of-pocket exposure is $375 per individual and $500 per family. [See Figure II.]

FIGURE II

Options for NCPA Employees

	Family	
	Conventional Policy[1]	Medical Savings Account Policy
Deductible	$500	$2,000
Maximum copayment	$1,000[2]	- 0 -
MSA deposit	- 0 -	$1,500
Total out-of-pocket exposure	$1,500	$500

[1] The figures in this column are per family member up to a maximum of three people.

[2] 20 percent of the first $5,000 of expenses above the deductible.

NCPA employees may use their MSA funds to see any doctor, enter any hospital or pay any medical bill. However, spending counts toward satisfying the deductible only if the service or procedure is covered under the health plan. For example, employees can pay for dental care or eye glasses with their MSAs, but those expenses do not apply toward the deductible. Furthermore, all spending counts toward the deductible only if employees see doctors within a network. If they go outside the network, only 75 percent of "usual and customary" fees are counted.

In the future, the buildup of MSA funds will give the employees important options with respect to expensive medical procedures. For example, the health plan will pay the full costs above the deductible only if the procedure is done by a network doctor in a network hospital. But employees will be able to use their MSA funds to go outside the network and pay that portion of the bill not covered by insurance.

Benefits of Medical Savings Accounts. Widespread use of MSAs would create the following benefits.

- People would have first-dollar coverage for primary or preventive care, using their MSA funds; this would be particularly beneficial for lower-income workers who may be short on funds and may be tempted to avoid basic care.
- MSAs would restore the doctor/patient relationship, making doctors agents of patients, rather than agents of a third-party payer bureaucracies.
- MSAs would allow patients rather than third-party payers to make the sometimes tough choices between health care and other uses of money.
- Paperwork and administrative costs would be greatly reduced; since patients would be paying most bills directly out of their MSA, primary care physicians would rarely be burdened by insurance forms.
- Those who live healthy lives and avoid risky behavior would benefit financially from those choices.

- MSAs would put the consumer, rather than an insurance company or the government, in charge of the health care system.

Answering the Critics of Medical Savings Accounts. The existence of plans like the NCPA's refutes most of the major criticisms against MSAs. It is ridiculous to argue, as some have, that the plan isn't actuarially feasible since the very existence of the NCPA employee benefit plan and 1,000 similar private plans prove the opposite. The argument that MSAs benefit the healthy, but not the sick is also easily refuted. A person with high expected health care costs benefits by choosing the new NCPA plan because his total financial exposure is $375, rather than $1,500 under the NCPA's old plan. For families, the exposure is $500 rather that $1,500.

Finally, the criticism that MSAs are incompatible with managed care is clearly untrue, since the NCPA's MSA plan has a managed care component. Although MSAs probably are inconsistent with the traditional philosophy of HMOs, efforts to make medicine cost-effective are natural allies of Medical Savings Accounts.

Under the NCPA plan, for example, the insurance company has established a preferred provider network (PPO) and has negotiated discounted rates with hospitals and other providers. But the employee is free to use that MSA money for the purchase of any type of medical care. Patients who go outside the network can pay for the full cost of the service from their MSAs.

Tax Fairness. If MSAs have all of these benefits, why haven't they become more widespread? The reason is the tax system. When an employer spends a dollar on health insurance, the employee escapes federal and state income taxes. But if the employer puts that dollar in an MSA to pay medical bills directly, it is taxed as income.

Because of this distortion, seven states have passed MSA legislation under their state income tax systems to create a level playing field between self-insurance and third-party insurance. Those states are letting people avoid the state income tax on money they set aside in a Medical Savings Account.

However, states have no control over federal tax law, which is why America needs the tax changes proposed in the Archer-Jacobs bill.

Health Care in the Information Age. The traditional philosophy of HMOs was summed up by an HMO manager several years ago: "Patients do what their doctors tell them to do; therefore, if you can tell doctors how to practice medicine, you can cut costs." This approach assumes that patients are compliant because they do not know what services they are not receiving.

A model based on patient ignorance, however, is unlikely to survive in the new Information Age. Increasingly, patients will use the Internet and other computer services to tap into various medical libraries and databases, discuss ailments with other network users and follow diagnosis decision trees. Thus, the best model for the future is one that assumes that patients will know as much as their doctors — not about how to practice medicine but about what medical practice offers.

One such model is Medical Savings Accounts. Using their accounts, patients will seek doctors who are financial advisors as well as health advisors. Physicians will be aided by sophisticated computer programs. No large bureaucracy will be required. When all patients have ready access to information, doctors acting as their agents will probably outperform most bureaucracies.

In order to take full advantage of the information age, however, Congress needs to give patients, health care providers and insurers the freedom to experiment with the most efficient and cost effective ways of providing quality health care.

Mr. CHRISTENSEN. Thank you, Dr. Goodman.

Since the NCPA, National Center for Policy Analysis, has its own medical savings plan, how difficult was it for you to convert from the health care plan a year or two ago to its current MSA type of plan?

Mr. GOODMAN. It was not difficult at all. Now, we are a small business. We only have 28 employees and, therefore, we cannot afford to give choices to our employees a larger organization could. We consulted with all of them, and whatever we did, it had to be the same plan for everyone.

Mr. CHRISTENSEN. Did you find that the MSAs have been deficient in providing health care coverage with respect to any particular type of health care; for example, hospital stays of specific types of medical procedures? Are there any deficiencies thus far in the plan; and what has been the overall general reaction of the employees?

Mr. GOODMAN. We have been in the plan since January 1, so we have not had a tremendous amount of experience with it. But it is comparable to other plans that other employers have had for a longer period of time.

The basic plan covers basic medical care, but there are certain things that we do not cover, and people can use their medical savings accounts, for example, to buy eyeglasses and certain other kinds of care that are not covered by the plan. Our employees have flexibility, and, of course, what they do not spend at the end of the year they get to take home and keep.

Mr. CHRISTENSEN. How much do you anticipate the MSAs saving your company in administrative costs?

Mr. GOODMAN. Our goal in making this transition was that I did not want the cost to the employer to increase. In the two columns that you are looking at, from two different insurance companies, the cost to us remained the same. My instructions were, let us put as much as we can in the medical savings account with no increased cost to the employer.

Now, what this means is that the savings we get under this plan, the employees get to keep it. That is true of most medical savings account plans. It is wrong to think of them primarily as designed to save money for the employer. They do not. Primarily, the people who economize and save money in their account get to keep it. That is a good feature of this kind of incentive system. It is designed so that those who economize get the benefits of their economizing.

Mr. CHRISTENSEN. Some States have already enacted legislation that would allow favorable tax treatment for MSAs. I know Michigan was one of them. We heard Congressman Chrysler testify earlier. How significant of an impact do you see H.R. 1818 having on the States and what specific legislation do you see would have to be enacted to accomplish that goal?

Mr. GOODMAN. At the State level?

Mr. CHRISTENSEN. Yes.

Mr. GOODMAN. Really, none. There are about 14 States now that have adopted medical savings accounts under their State income tax laws. But what most States do is they piggyback on the Federal Tax Code. So, if medical savings accounts were created under Fed-

eral tax law, it would automatically be created under most State income tax systems.

Mr. CHRISTENSEN. My final question would be how could we improve H.R. 1818? Any suggestions for improvement?

Mr. GOODMAN. Well, I would allow the money to grow tax free. I cannot tell you now what the revenue loss as a result of that decision would be. But, I think it ought to function like a normal IRA. That money should grow tax free. Certainly if when you pull it out you are going to pay taxes plus a penalty, you should get the benefits of tax free growth. But I support the act as now written.

Mr. CHRISTENSEN. Thank you very much.

Mr. Crane, any questions?

Mr. CRANE. Thank you, Mr. Chairman.

Mr. Hustead, if I read your testimony correctly, on balance, your group thinks that medical savings accounts will be able to deliver quality health care at a reduced rate; is that a correct reading?

Mr. HUSTEAD. I think we say that if we are looking at a traditional fee-for-service plan and raising the deductible, that should be able to deliver the same health care as now at a reduced rate, yes.

Mr. CRANE. Have you ever designed an MSA plan for a client?

Mr. HUSTEAD. No, I have not.

Mr. CRANE. Have any of you had any experience in that realm?

Mr. HENDEE. I have designed one medical savings account program and am currently designing another. Designing a program generally involves raising the deductible and determining how much money would be saved as a result of raising the deductible, and then the employer makes a decision as to the appropriate level of contribution to the account.

Mr. CRANE. I have heard that with a $200 deductible in contrast to a $1,500 deductible policy, the differential in premium cost is almost four to one. Does that sound reasonable? In other words, you would be paying four times as much for a $200 deductible than for a $1,500 deductible.

Mr. HENDEE. It would depend a lot on the program of benefits that you provided. The report of the Committee that Mr. Hustead chairs indicates that for a change comparable to the one you described, the savings would be on the order of $600 to $800. That is my recollection, for that change in deductible. And depending on what the total program of benefits was, that amount of money could be a different percentage of the original premium.

Mr. CRANE. Thank you very much. Dr. Goodman.

Mr. GOODMAN. Well, if you look at market prices for insurance around the country, you will see that the amount you save in premiums by choosing a high deductible over a low deductible varies. The most significant variable is how high are the health care costs in the region generally. So, if you are in a high cost city, like New York or Los Angeles, you will save much more by going to a higher deductible than you will if you are in a low cost area or even an average cost city like Dallas.

Mr. CRANE. I see. Thank you very much.

Mr. CHRISTENSEN. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Mr. Hustead, you have produced, I suppose, the most comprehensive report of this MSA concept. Did the insurance companies that

do a lot of high-deductible assist or enter your review? Or were they contacted at all?

Mr. HUSTEAD. We did get information from a lot of insurance companies who sell individual products and the report does reconcile our numbers with those individual products. We did go to those employers who have said that they have MSA accounts that are saving substantial money and in several cases we got information, but it was fairly scarce. In other cases, we were not provided any information. We did provide in the report the information that was provided by several of these organizations.

Mr. STARK. Is that usual, that they will not give you policy information?

Mr. HUSTEAD. Well, the insurance policy information we got, because that is public information. The information on how employers are managing their own plans, now, that often is not available because so many confusing things are happening within the organization. They would have had to do a fairly good analysis process.

But I think we threw out our net and with our members were able to get all the information that does exist on these plans.

Mr. STARK. Mr. Goodman, you are referred to as the father of MSAs. Who is the mother? It seems to me that the chief contributors to the National Center for Policy Analysis are Golden Rule Insurance. And Pat Rooney, he is the director; isn't he?

Mr. GOODMAN. The premise is not correct. The chief contributors to the NCPA—or should I say the chief contributor is not Golden Rule Insurance Co. Golden Rule makes an annual contribution of about $60,000 to our organization.

Mr. STARK. And Mr. Rooney is the director?

Mr. GOODMAN. No. He is the chairman of the Golden Rule. Our annual budget is $3 million, and so that is a small part of our——

Mr. STARK. How much of the $3 million comes from insurance companies?

Mr. GOODMAN. Pardon me?

Mr. STARK. How much of the $3 million comes from insurance companies?

Mr. GOODMAN. Probably less than $100,000.

Mr. STARK. Golden Rule is the big one, then.

Mr. GOODMAN. Yes.

Mr. STARK. OK. We asked if you would send us more detail on your plan. I presume you are going to send that on to us.

Mr. GOODMAN. Yes, I am. I received your note and I looked at my plan and learned something I didn't realize, and might not have realized had you not requested it. Our plan does not include a reference to medical savings accounts.

In other words, our contract with the insurance company is just a high-deductible policy and the plan pays for all expenses over $2,000. We have a separate arrangement with a third party administrator to manage our medical savings accounts. But, I will be happy to send you the contract.

Mr. STARK. Yes. As I say, I would be interested because just as Mr. Hustead said, some of these are a little hard to focus on just what the terms are, and if one was writing legislation to enact them, it would be helpful to know what the state of the art is.

[The following was subsequently received:]

Golden Rule®

THE MEDICAL SAVINGS ACCOUNT PLAN PARTICIPATING EMPLOYER APPLICATION

Home Office
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439

Trustee: National City Bank, Indianapolis, Indiana

Section 1 EMPLOYER INFORMATION

Company's Legal Name: National Center for Policy Analysis

Business Address: 12655 N. Central Expwy. Ste. 720 (Street) Dallas (City) Tx. (State) 75243 (Zip) Dallas (County)

Contact Person: Rena Brand Phone: (214) 386-6272

Nature of Business: Thinktank on policy issues How Long in Business _____ years

Section 2 OTHER INSURANCE INFORMATION

Has an insurance carrier terminated your coverage within the last five years? If yes, provide name of carrier: no

Please check the number of insurance carriers you have had in the last 3 years: ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than five

Is this insurance being applied for to replace other group health insurance coverage? Yes ✓ No ____ If yes, please submit a copy of current or prior carrier's coverage and last bill with employees' names.

Effective Date: 11/1/91 Company Name: Pacific Mutual

Policy or Group No.: 13095

WE SUGGEST THAT YOU NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE THE CERTIFICATES OF COVERAGE FROM GOLDEN RULE.

Section 3 EMPLOYEE AND DEPENDENT INFORMATION

A. Total Number of Employees (Part-time and full-time) 18

B. Total Number of Full-Time Employees (A full-time employee is one who works at least 30 hours per week and 48 weeks per year.) 18

C. Total Number of Qualified Employees (Full-time employees not declining this medical coverage due to other group health insurance coverage.) 14

D. Total Number of Qualified Employees Requesting Medical Coverage 14
Note: Groups with 51 or more employees: the number in response D must be at least 75% of all qualified employees (response "C") and at least 60% of all full-time employees (response "B"). Groups with 3-50 qualified employees: the number in response D must be at least 90% of all qualified employees.

	Yes	No
E. Is any employee/dependent currently on a continuation of benefits under COBRA or State Continuation Law?	☐	☑
F. Has any employee/dependent qualified for a continuation of benefits under COBRA or State Continuation Law and not yet elected to continue coverage?	☐	☑
G. Has any employee or their dependents had claims in excess of $7,500 in the last two years? If yes, please list the employee's name(s). _____	☐	☑
H. Do you contribute at least 50% of the premium cost of coverage for your employees?	☑	☐

I. Please list any employee who is not actively at work.

Name	Reason
n/a	

RECEIVED
DEC 16 1994
GROUP NEW BUSINESS

Please list any employee or dependent who has had coverage rejected by a previous carrier.

Name	Reason
n/a	

Section 4 COVERAGE INFORMATION FOR NEW EMPLOYEES

A. Waiting period for new employees. You must choose one ___ 0 Days* ___ 30 Days* X 90 Days
*Not available to groups with 3-50 employees.

B. Life Insurance and Accidental Death and Dismemberment Insurance (AD&D).

Employee Classification	Amount of Life Insurance	Amount of Weekly Disability Income Insurance (optional)
All	$15,000	

C. Deductible Option (Single employee deductible/family deductible
You must choose one
☑ Plan I $1,500 Single/$2,000 Family
☐ Plan II $2,000 Single/$3,000 Family

D. Coinsurance Option PPO
You must choose one
☑ 100% coverage after the deductible
☐ 80/20 coinsurance to $5,000 per covered person

E. Optional Coverage
☑ Maternity (same as any illness)
☐ Weekly Disability Income
☐ Dependent Life - Option A
☐ Dependent Life - Option B

Section 5 EMPLOYER AGREEMENT AND REPRESENTATIONS

The Employer represents that the Producer of Record has (a) provided employer and employee brochures; and (b) discussed group eligibility, contribution requirements, participation requirements, precertification requirements, provisions for preexisting conditions, and that the Employer fully understands these requirements and provisions.

The Employer understands and agrees:

(a) to make timely payments of the required premiums billed by Golden Rule;
(b) that Golden Rule has the right to change premium by class as necessary (Premium factors include age, gender, claims experience, employee participation, geographic area, and the length of the Employer's participation in the plan);
(c) that the Underwriting Department may call the Employer and employees at the Employer's place of business to develop information to enable Golden Rule to make a prompt underwriting decision;
(d) that the Producer of Record: (1) is an independent contractor assisting the Employer; (2) not an agent of Golden Rule; and (3) cannot bind coverage or change or modify conditions of coverage; and
(e) to comply with Golden Rule requirements regarding the insurance plan, as set forth in the policy or communication in writing by Golden Rule.
Specifically, the Employer warrants and represents that:
(1) Employer has provided Golden Rule with the names of all full-time employees, even if they do not intend to be insured by Golden Rule;
(2) Employer will provide Golden Rule with the names of all new employees and new dependents, even if they do not intend to be insureds; and
(3) all information on this form is true and correct.

Section 6 JOINDER AGREEMENT

The undersigned Employer, desiring to obtain the benefits of group insurance for its employees, hereby agrees to join one of the Golden Rule Trusts as a Participating or Enrolled Employer. If approved by Golden Rule, the Employer accepts and agrees to be bound by the provisions of: (a) the Agreement and Declaration of Trust dated July 30, 1977, as amended, which created the Trust; and (b) the Master Insurance Policy issued to the Trustee by Golden Rule. The Employer understands that the documents referred to in items (a) and (b) are subject to future amendments.

Signed at Dallas, Tx on 12, 7, 94 (Month, Day, Year)
Employer Signature Rena K. Brand Rena K. Brand
Employer Name National Center for Policy Analysis Title Dir. of Administratio

MET-AF-12 42

PRODUCER'S STATEMENTS

I hereby certify that all of the information herein is complete and correct, that the firm is a bona fide business establishment, and that I know nothing unlavorable about the group. I certify that each employee has completed the employee application with his or her own hand. I further certify that I have complied with all of Golden Rule's rules and requirements; (2) I have explained to and the Employer fully understands the provisions for preexisting conditions and precertification; and (3) I have explained to the Employer the requirements for contribution and participation and these requirements are being met. I have instructed the Employer to not cancel current group coverage before certificates of insurance have been issued by Golden Rule Insurance Company and delivered by me.

Signed at Dallas, Tx on 12, 7, 94 (Month, Day, Year)
Producer Signature
Producer Name James Waldron CLU Producer Number 258-40-7361 Phone Number 214-231-9531

496A 194

Mr. STARK. Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Thank you, Mr. Stark.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Gentlemen, thank you for coming today. I am sorry I missed part of your testimony but I am familiar with the concept, having been a promotor—not the father—but a promotor of this concept for some time. I appreciate the work Dr. Goodman has done on this.

Dr. Goodman, just to clear up one thing, you said that the savings under this type of plan go to the individuals involved and not to the employer. But isn't it true that as an employer you anticipate savings in the future in terms of future increases in your premium costs to cover your employees?

Mr. GOODMAN. Well, that's correct. What we did in moving from 1994 to 1995 was we held our plan costs constant, and for the future we anticipate that as employees save money for themselves they will also save money for the organization.

Mr. MCCRERY. I just wanted to clear that up.

At the end of your testimony, Dr. Goodman, you state that Congress should give patients and health care providers the freedom to experiment with ways to provide quality health care more efficiently and effectively.

Can you give us some examples of that?

Mr. GOODMAN. Well, what we have now is an income tax structure which encourages third party payers to pay every medical bill because the payment of third party premiums is excluded from the taxable income of the employees.

What we recommend and what this bill does is make self-insurance through medical savings accounts just as attractive under the Income Tax Code as todays third party premiums are. And if you create a level playingfield, what you will do is allow insurers, employers and employees to be more flexible and come up with options that none of us have considered here this morning. We should not have people making these decisions based on tax advantages. We should allow them to make these decisions based upon health care needs and the economics of the health care marketplace.

Mr. MCCRERY. Well, for example, someone might use some of his MSA money for a physical exam that might not have been covered under a traditional insurance policy; is that correct?

Mr. GOODMAN. That is correct.

Mr. MCCRERY. OK.

Mr. Hustead and Mr. Hendee, you know, we have a very limited experience so far with MSAs though hope to get more in the future. Can you comment on what you think the stability of the premium for a high-deductible policy might be over time?

Mr. HUSTEAD. Well, while there may be little experience with MSAs, there is a good deal of experience on ranges of options like in the Federal employees health benefits program. And generally you find that once the employees sort them out into the various plans, low-deductible, high-deductible, HMOs, and so forth, that the cost of each of the plans tend to rise at about the same rate. So, they are fairly stable once you go over the initial sorting out of people.

Mr. MCCRERY. Mr. Hendee, do you have any comment on that?

Mr. HENDEE. I would agree that the increase would tend to be similar under both programs.

Mr. MCCRERY. You do not see a danger if a great segment of the market were to go toward high-deductible policies? You do not see a danger that that kind of instrument would—the premiums for that kind of instrument would grow more than we have experienced under the current system?

Mr. HUSTEAD. No. There would be the initial reaction in the simple case of just having the low- and high-deductible plan that the cost of the low-deductible plan would go up as the healthier people move to the high-deductible plan. But then the premiums, once that initial change happened, would rise at about the same rate.

Mr. HENDEE. I believe that actually the rate of increase of all policies would decrease. This is in the academy's report, HCFA research has shown that as the percentage of health care costs that are paid by third parties increases, so does health care inflation. So, moving to catastrophic policies will decrease the percentage paid by third parties and, hopefully, would decrease the health care inflation.

Mr. MCCRERY. OK. Thank you very much.

Mr. CHRISTENSEN. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. I am having a difficult time reconciling the testimony from Mr. Hustead and Dr. Goodman. Let me see if I can try to set this up and get a response from both of you.

Mr. Hustead, you indicated that if you move from a $200 deductible to a $2,000 deductible, that an employer would start $828 in premium savings, on average, if I am reading your chart correctly.

Mr. HUSTEAD. That is correct.

Mr. CARDIN. Yet, Dr. Goodman has indicated that his firm moved from a $500 deductible to a $2,000 deductible, and the $500 deductible policy had copayments up to $1,000 and that the savings to his company were $1,500, that he was able to put into the medical savings accounts. If I understand, it was at no additional cost to the employer to put the $1,500 in the medical savings account.

Dr. Goodman also indicates that he comes from an average cost community. So, it did not seem like it was high cost. How do we reconcile what appear to be significant differences in the potential savings from what Mr. Hustead has come up with and what Dr. Goodman is experiencing? Any explanation?

Mr. HUSTEAD. Well, the very reason for the organization of our work group last year, is that as actuaries would testify before Congress and give their evidence, there seemed to be this great difference in the actuarial community. We got together people from we think, all ranges of view on this topic and sat down and said, when we put our models together and look at experience based on millions and millions of lives over many years, what are the actual facts, what is really happening here.

We also, as indicated earlier, went out to the insurance companies and to people who had MSAs and said, what are your findings? Let us make sure we get this all stated together. And the range of opinion among the actuaries, based on this body of data was fairly narrow. Some of us, depending on the situation, might

say, well, you could reduce the premium by $800, some $600, but, generally, we found our models to be quite consistent.

Of course, if you have any individual cases, as I understand Dr. Goodman has, and, of course, as he says, it has just started so really we do not know what the situation will be, but if you just have 20 or 30 people, you could easily have cost savings of $1,500 or $2,000 if you have cost increases.

Mr. CARDIN. I will give Dr. Goodman a chance, if I might. Using your figures, the $828 savings, that gets eroded if it is a small amount that the employer puts in, if I understand your testimony, unless the employee buys in, this is not really my savings for health care, the savings are not as much. And if there are other options allowed under the employer's plans, only the healthier people will likely opt into the medical savings account. Is that right?

Mr. HUSTEAD. It is a caution we make that those type of things could happen. We think, or at least I think, that a large employer with a number of options in their plan, can control that situation. But if you take a group where you do allow current options to continue and where you do set up the MSAs; if you compare the savings to what would occur if you moved everybody to a high-deductible plan, you generate less savings if you allow selection to occur.

Mr. CARDIN. Dr. Goodman, if I understand your plan, you only have that one plan so your employees are in the high-deductible plan.

Mr. GOODMAN. That is correct.

Mr. CARDIN. So, you do not run that risk.

Also, you are putting a significant amount of money into their savings accounts so they really do have an interest in trying to save some money.

Mr. GOODMAN. That is correct.

Mr. CARDIN. Have you experienced this type of savings, the $1,500, and is that net of the tax advantages? You are not getting a tax advantage right now.

Mr. GOODMAN. No, we are not. We have to pay taxes on all the money deposited, which is a feature the Archer bill, of course, would change. But we do pay taxes on it, even if the money is spent on medical care. We have to pay taxes on the deposits to the medical savings account.

Mr. CARDIN. You believe that you will be able to realize a $1,500 per employee savings that you are giving back to the employees through the medical savings accounts.

Mr. GOODMAN. We have already done it.

What we did was we held the employer's total cost constant and saved enough to put $1,500 in the medical savings account. Now, employees will spend part of that money. In fact, we anticipate half the money will be spent by employees on medical care.

Mr. CARDIN. Trying to look at this from the employer's point of view right now. From the employer's point of view, it came out no additional cost.

Mr. GOODMAN. That's right.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. Goodman, in your testimony you noted that the NCPA and an insurance company established a preferred provider network. Can you tell the Subcommittee a bit about how this PPO agreement was achieved?

Mr. GOODMAN. No, I really can't, except it appears on the surface to me to be a very normal preferred provider arrangement in Dallas. It includes a large number of doctors and our employees do not feel constrained by operating within the PPO network, although some may choose to go outside it.

Mr. ENSIGN. Since the NCPA was able to establish a PPO, don't you think this factor is a very strong indication that MSAs can be integrated into the existing health care system?

Mr. GOODMAN. Oh, yes. In fact, we have done it. And in fact most private plans that have medical savings accounts are integrated with some sort of managed care.

Mr. ENSIGN. Thank you. And thank you, Mr. Chairman.

Mr. CHRISTENSEN. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I recall Premier Gorbachev being here and he gave us a warning once talking about how you get along with Americans. He said you can always agree sort of on the general principles but the devil is usually found in the details. And I sort of have the feeling that we are talking a little bit about the details here today.

Mr. Christensen was kind enough to pass out a card for one of these medical savings accounts and I just absentmindedly started reading the back side of it and since you guys are actuaries, and you have these plans out there, I wonder if your card said something like this on the back. It says: "Medical precertification is required at least 7 days prior to admission, surgery, or home health care. For emergencies call in 24 hours. If not certified, benefits may be reduced." Then it says this sentence, which I wondered if you would have on your card, "Certification is not a guarantee of payment."

Now, if the doctor tells me I need to go in and have my gallbladder taken care of, and I call up 7 days in advance and say I am going to the hospital, my doctor has ordered me in to have my gallbladder removed, and they say, well, yeah, we will certify that, what does that line mean, "Certification is not a guarantee of payment"? Does that mean after I'm out of the hospital I will have to argue with them?

Mr. HUSTEAD. It could well be. I do not think this is language that is limited to MSA. This is typical language for health plans.

I think the warning they are getting at is that—while the insurer will precertify your need to be in the hospital, if you, say, go on for 4 or 5 days, when the health plan says you should only be limited to 3 or 4 days, the plan will not pay the extra days.

Mr. MCDERMOTT. What they are certifying is 3 days in the hospital to have your gallbladder out. They do not tell the patient that, they just say, yes, you can go have it done, but hidden in the drawer is the chart that says, after 3 days out, you go, ready or not, or you will pay it yourself. Is that what you are suggesting?

Mr. HUSTEAD. I think what happens is, that the doctor and the insurer and the hospital work together on the issue with the pa-

tient's knowledge. But it is more of a legal statement that says just because you get in does not mean we will pay the whole bill.

Mr. MCDERMOTT. So, people should read this card very carefully if they decide they want to get involved in it.

Mr. HUSTEAD. That is correct.

Mr. MCDERMOTT. Let me ask a question about the plan. Dr. Goodman, could you tell me, the people who are in your plan, what is the age range? What is the oldest person and the youngest person in your plan?

Mr. GOODMAN. Oh, my gosh. Probably 65, 64; 65 would be the oldest and 19 or 20 would be the youngest.

Mr. MCDERMOTT. What is the average?

Mr. GOODMAN. Approximately 35.

Mr. MCDERMOTT. Thirty-five. So basically healthy young people?

Mr. GOODMAN. Yes. Reasonably healthy.

Mr. MCDERMOTT. Reasonably healthy.

Mr. GOODMAN. We have some employees with health problems.

Mr. MCDERMOTT. And when they pay money for their health care, they reach into their medical savings account to pay for something, does that money get counted against their deductible under the health plan; or is it only on certain procedures that are covered in the health plan that to be counted toward the deductible?

Mr. GOODMAN. As long as it is a covered expense, it is counted against the deductible. If they stay within the network, all they spend counts against the deductible.

Mr. MCDERMOTT. But if they have—so if the medical savings plan is very narrow—for instance, does it include mental health benefits?

Mr. GOODMAN. Some mental health benefits, but I cannot tell you the extent of them.

Mr. MCDERMOTT. So, if they go beyond this narrow little mental health benefit, then anything they spend beyond that would not be counted against the deductible?

Mr. GOODMAN. I did not say it was narrow or little. There is some mental health benefit, but I cannot tell you the extent of it. But once they go outside the plan, which they are free to do and they have the money that allows them to do that, that does not count toward the deductible.

Mr. MCDERMOTT. I see. So, they could really spend their whole account outside of the plan on medical benefits, since the definition of medical benefits for which the medical savings account could be used is a fairly broad one. But the plan might be narrow, and, therefore, would never count against the deductible. Then, if they had a big problem, they would have a big deductible all of a sudden.

Is that a fair assessment of a potential problem?

Mr. GOODMAN. That is fair, but that same statement could be made about the conventional plan that we had last year. In other words, the movement to the medical savings account did not really change the range of benefits employees were entitled to. What it does is it allows them to manage more of their own health care dollars.

Mr. MCDERMOTT. So, you are saying that the Continental and the medical savings account up there on that chart, the benefit packages are exactly the same?

Mr. GOODMAN. Roughly the same.

Mr. MCDERMOTT. Roughly the same.

Mr. GOODMAN. Yes.

Mr. MCDERMOTT. What is the difference?

Mr. GOODMAN. Well, I cannot tell you that every comma and period is the same, but, roughly, they are the same benefit structure.

Mr. MCDERMOTT. But there is a $500 deductible on one and $2,000 on the other. That is where I am having my trouble figuring out——

Mr. GOODMAN. That has to do with the part to be paid by the patient. But the services covered by the two plans are virtually the same. How much mental health is covered by the two plans is the same in both cases.

Mr. MCDERMOTT. Is there alcohol rehabilitation in the plan?

Mr. GOODMAN. I'm sorry?

Mr. MCDERMOTT. Is there an alcohol rehabilitation benefit in the plan?

Mr. GOODMAN. I cannot tell you. I do not know.

Mr. MCDERMOTT. I see.

Thank you, Mr. Chairman. I would like to have—I also would like to see a copy of your actual plan that people have, so we can actually look at what this card guarantees them to or does not guarantee them to.

Mr. GOODMAN. That is not our card.

Mr. MCDERMOTT. I understand that. We will get the plan from this one, too, but I would like to see yours, because I think people will get caught in the details. What sounds like a good idea, you can manage your own health care money, presumes you know what is going to happen to you. None of us know and people are going to get squeezed by this thing.

Mr. GOODMAN. Mr. Chairman, may I respond to that?

Mr. CHRISTENSEN. Yes.

Mr. GOODMAN. The restrictions that are there on that card have nothing whatever to do with medical savings accounts. Those are the kinds restrictions that are being imposed on people by managed care plans all over the country. And what medical savings accounts do is, it gives people a little bit of freedom, and a little bit of control over their own health care dollars so that every decision is not made by the managed care bureaucracy.

Mr. MCDERMOTT. I would just, in answer, it is on a medical savings account. It is the RCI medical savings account, so it is the same as HMOs. Whatever you think you are getting away from in an HMO, you will meet it coming around the corner in this.

Mr. CHRISTENSEN. The gentleman's time has expired. The card the gentleman is holding up is the MPO, Michigan Provider Organization. It is a managed care network and it is an example of RCI. So, it is part of managed care.

I will recognize the gentleman from Louisiana, Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman, and, Mr. McDermott, you might want to check your insurance policy. I have checked mine. I get it through the Federal employees health benefits pro-

gram, and on the back it says "Precertification is required for all hospital admissions and is ultimately your responsibility." I think you will find that it is the same——

Mr. MCDERMOTT. I have the same card. My point was this is not giving people any——

Mr. MCCRERY. If the gentleman would like me to yield.

Mr. MCDERMOTT. Yes. You brought it up. This medical savings account does not give you anything, because you are in the same box. The insurance companies have got you in the vice.

Mr. MCCRERY. Well, except for the first $2,000, you have pretty much total freedom. You are not dependent upon the insurance company, you are dependent on yourself. So, there is a great difference between the two.

Reclaiming my time. I just want to say to the gentleman that everybody needs to read the back of their card, in fact, their whole policy.

If I can shift the focus for just a second to HMOs, HMO type managed care plans, I want to address this to Mr. Hustead and Mr. Hendee. Are there risk selection problems associated with HMOs in the marketplace?

Mr. HUSTEAD. Any option has risk considerations with it.

Mr. MCCRERY. But are there risk selection problems, particularly associated with HMOs in today's climate?

Mr. HUSTEAD. I am not——

Mr. MCCRERY. In other words, is there a fear or do we know that healthier people tend to gravitate toward HMOs? Is there a risk selection problem in today's marketplace with HMOs?

Mr. HUSTEAD. I think, in general, the studies have shown healthier people, younger people have selected HMOs over the years, yes.

Mr. MCCRERY. Mr. Hendee?

Mr. HENDEE. Yes, the common expectation is healthier people do move toward HMOs.

Mr. MCCRERY. And what about MSAs, are there risk selection problems associated with MSAs; and, if so, are they roughly comparable to those associated with HMOs, or are they greater? Less than?

Mr. HUSTEAD. It depends on the group. I think the same general forces are there, in that the people—I guess if we are saying who will stay with the traditional fee-for-service, low-deductible plan and not go to an HMO or a high-deductible plan, people that need the most health care tend to stay there because it provides the greatest benefit. With a large employer, who will now look at the MSA and high-deductible option, these are the types of selection questions they have dealt with for years, and I think they can successfully monitor and deal with selection to make the effects what they want them to be.

So, I do not think the introduction of high-deductible plans introduces any large new selection problems compared to what has gone on in the past.

Mr. MCCRERY. Mr. Hendee.

Mr. HENDEE. The selection may actually go in the other direction, to some degree, because people who do have some medical problems and want to preserve their choice and not be restricted

by case management may prefer to go with a medical savings account and the high-deductible plan, whereas under the current situation they would stay with the low-deductible plan to preserve their choice.

Mr. MCCRERY. So, are you saying that there is——

Mr. HENDEE. You are not necessarily just going to get the low cost people moving to the MSA.

Mr. MCCRERY. Is it your opinion that the risk selection problems associated with MSAs is no greater than that associated with HMOs.

Mr. HENDEE. I agree that an MSA option produces selection concerns comparable to those produced by an HMO option. Depending on the specific situation those concerns may be greater or less.

Mr. MCCRERY. OK. Thank you.

Mr. CHRISTENSEN. I thank the panel for their testimony.

I would now call up the next panel, Hon. Bret Schundler, Jean Samuelson, and Charles Rateliff.

Chairman THOMAS [presiding]. I want to welcome the panel and tell you that if you have a statement we will make it a part of the record without objection, and you can address the Subcommittee in any way you see fit in the time available to you. And we will go first with the mayor of Jersey City, New Jersey, Hon. Bret Schundler.

STATEMENT OF HON. BRET SCHUNDLER, MAYOR, JERSEY CITY, NEW JERSEY

Mr. SCHUNDLER. Thank you for allowing me to join you today. I want to express my strong support for H.R. 1818, the Family Medical Savings and Investment Act of 1995, which grants contributions to medical savings accounts with the same sort of tax deductibility now permitted only for the payment of health insurance premiums. I think this is the most constructive and important piece of health care reform legislation that this Congress will face.

Last year, Jersey City, New Jersey, was one of the first public entities in the United States to provide MSAs to its employees. Previously, all of our employees were in the medical—what is called the State health benefits plan, which provides three options for our employees. One is a standard, low-deductible indemnity policy; the second is an HMO; and the third is a preferred provider option plan.

What we have done is added a fourth option which is a catastrophic policy with a medical savings account. And I might add the catastrophic policy mirrors the State low-deductible policy. So, the benefits that are covered are 100 percent the same, but what you have is a higher deductible with the MSA option.

Right off the bat, 56 percent of our eligible employees chose the MSA option over their previous coverage. And we expect that percentage to rise to over 90 next year. Moreover, for every employee who has chosen the MSA option, the city has achieved immediate budgetary savings of $500, and we expect even greater savings to be realized in the future.

Now, how has the MSA been able to please both our employees and reduce our health care costs? The answer is relatively simple. In the past, Jersey City covered its management employees

through the New Jersey State health benefits plan, as I mentioned. Most chose the fee-for-service option where employees had to pay a $200 front end deductible and a 20 percent copayment on the first $2,000 of expenses for each covered family member.

That means if you had a family of four you could have potential out-of-pocket expenses of up to $1,800 in medical expenses. That would be 20 percent of $2,000 times four people, plus another $200 up front deductible. So, that comes to $1,800.

Under the MSA plan, the city purchases that catastrophic insurance policy that covers 100 percent of the family's medical costs above $2,000. Then we put $1,800 into the medical savings account. This gives the family the opportunity to draw on that medical savings account to cover the first $1,800. They cover out-of-pocket the next $200. And above that $2,000 limit, the insurance covers 100 percent of their expenses.

If at the end of the year there is money left in the medical savings account, they will get a check for the unused portion of the account. It is not hard to see why the MSA plan is more attractive. If family health care costs are high, family out-of-pocket expenses will be less under the MSA than under the previous low-deductible policy most of our employees chose.

To be precise, for a family of four, the out-of-pocket exposure goes down from $1,800 to $200. Now, if the health care costs are low, the family will actually have money rebated to it, representing whatever is remaining in the MSA. Obviously, the prior low-deductible policy never rebated money to you if you had low health care costs.

The reason we expect to see over 90 percent next year is when those rebate checks go out I suspect those who chose not to look at the MSA plans just may reevaluate their medical health plan needs.

Now, the cost to the city again is down by $500. Last year, it was $6,800 for everybody who chose the standard plan. Now it is $6,300 and costs us $4,500 for the catastrophic insurance policy and $1,800 for the cash contribution. So, that is a savings of $500 per family.

We also expect to save even more money in the future as, again, employees begin to look for value in the way they spend their money. Forbes, Inc. has been able to reduce its health care premiums by approximately 25 percent in the 3 years they have had their plan in effect.

I know that the critics of MSA argue that many families, lured by the prospect of a check at the end of the year, may not get necessary care. I have to say from personal experience that is not the way MSAs work. I recently went in for foot surgery to treat a recurring ailment and at the end the doctor offered to give me a padded shoe, for instance. I simply said, I do not need that, I already have one at home. I might not have even brought up the subject had there not been a financial incentive to actually reduce my medical cost.

The bottom line is that the American people are not afraid to make informed judgments about their own health care needs. What they are afraid of, however, is losing the opportunity to make their own judgments because of third party rationing. If we can control

health care costs by maintaining choice and incentivizing citizens to get what is good for them, and what actually makes fiscal sense for all of us, that is a great power and that is a great positive.

I would like to conclude by simply saying I think Congress should immediately offer medical savings accounts to federal employees. It would represent a far greater savings to the American taxpayer if you make this available as an option. You do not have to replace anything you offer your employees today. You should simply give them an additional option.

I might add, if you did the same with Medicare and Medicaid you would dramatically reduce health care costs in America. If you have that combined effect with Jersey City and Medicaid/Medicare and Federal employees all having an MSA option, I think you will take the wind out of health care inflation.

In short, I would like the Ways and Means Committee to move quickly to pass the Family Medical Savings and Investment Act of 1995. Thank you very much.

[The prepared statement follows:]

STATEMENT OF HON. BRET SCHUNDLER, MAYOR, JERSEY CITY, NEW JERSEY

Chairman Thomas and Members of the Subcommittee on Health:

I would like to express my strong support for HR 1818, "The Family Medical Savings and Investment Act of 1995," which grants contributions to Medical Savings Accounts (MSAs) with the same sort of tax deductibility now permitted only for the payment of health insurance premiums. This is the most constructive and important piece of health care reform legislation that Congress will entertain this year.

Last year Jersey City, New Jersey was one of the first public entities to provide MSAs to its employees. The results have been extremely positive. Right off the bat, 56% of our eligible employees chose the MSA option over their previous coverage -- and we expect that percentage to rise to over 90% next year. Moreover, for every employee who has chosen the MSA option, the City has achieved immediate budgetary savings, and we expect even greater savings to be realized in the future.

How has it been possible for us to both please our employees and reduce our health care costs? The answer is relatively simple.

In the past, Jersey City covered its management employees through the New Jersey State Health Benefits Plan. Most chose a fee-for- service option, where employees had to pay a $200 front-end deductible and a 20% co-payment on the first $2,000 in expenses for each covered family member. That means a family of four had potential out-of-pocket expenses of up to $1,800 in medical expenses annually.

Under the MSA plan, the city purchases a catastrophic insurance policy that covers 100% of a family's medical costs above a $2,000 deductible. The city then places an additional $1,800 in a medical savings account that the employee can draw down upon for payment of most of that deductible. Putting these elements together means that a family of four would, at most, have to pay $200 in out-of-pocket deductible expenses. Moreover, if a family's total health care costs fall below $1,800 in a given year, the money remaining in the MSA account will be refunded to the employee at year's end.

It's not hard to see why the MSA plan is more attractive. If family health care costs are high, family out-of-pocket expenses will be less under the MSA than under the standard policy most employees had previously chosen. If family health care costs are low, the family will actually get the money left over in the MSA rebated back to them, which doesn't happen under most insurance plans.

The cost to the City for family coverage under the State Health Benefits Plan was $6,800 per year and rising (premiums had doubled in just the last five years). The cost to the City to offer the MSA option is only $6,300 -- $4,500 for the catastrophic insurance policy, and $1,800 for the cash contribution to the Medical Savings Account.

What a deal! We've been able to obtain better coverage for our employees, which lowers their out-of-pocket expenses and maintains their ability to choose their own doctor while lowering total health care costs for the City!

Because of the MSA's rebate potential, we expect even larger savings in the future, as our employees are incentivized to avoid gratuitous expenses, and the reduced claims experience that results translates into lower premiums. For example, Forbes, Inc. has been able to reduce its health insurance premiums by approximately 25% by offering MSAs to its employees, while most other employers with traditional fee-for-service insurance plans have seen their health insurance premiums increase.

The critics of MSAs argue that many families, lured by the prospect of a check at the end of the year, will be tempted to forgo the medical care they need. But that's not how MSAs work. I can share a personal experience about how MSAs eliminate wasteful medical spending. Last week, I had minor foot surgery to treat a recurring ailment. After the procedure, my doctor offered me a padded shoe, but I refused because I already

had one at home from an earlier procedure. Because I was enrolled in an MSA, I had an economic incentive to refuse something I just did not need. In contrast, if an insurance company were going to be picking up the entire tab, what incentive would I have had to say anything?

The bottom line is this: the American people aren't afraid to make informed judgements about their own health care needs. As consumers, we make thousands of purchasing decisions each and every year. What we do fear is losing the right to make choices for ourselves through third-party rationing. We don't think government, or our employer, should have the power to determine what health care we are eligible to receive. We want to retain that power unto ourselves. And that's why MSAs are so popular -- they keep the power to choose in our hands as patients, instead of putting it into the hands of government, employers, insurance companies, or health care providers.

"The Family Medical Savings and Investment Act of 1995" will make MSAs even more attractive and will accelerate their usage. It will stop the foolish practice of treating funds that an employer deposits into an MSA as taxable income. Under HR 1818, only the unspent funds that an employee is rebated at year's end would be taxable. Individuals would also be given the option of starting a "medical IRA," whereby unspent funds accumulated from their MSAs could be saved, tax-free, for future medical expenses. This too is a great idea, which will expand the affordability, and portability, of health insurance.

Unlike most tax expense legislation, HR 1818 will not put a dent in the federal treasury. Right now, employers deduct 100% of their employees' health insurance premiums as a business expense. This practice will continue with MSA contributions treated the same way as premium payments, but because total health care costs to the employer will decrease with MSAs, the cost to the Treasury of this tax exclusion will also decrease. Further, when employees are rebated any extra funds remaining in their MSAs at year end, this additional personal income will be taxable.

I would recommend that Congress take this proposal one step further and offer MSAs as a voluntary option to federal employees, as well as to Medicare and Medicaid recipients. It would improve the coverage provided by these programs, reduce their cost, and slow down their future cost growth -- again, not by third-party rationing, but by giving individuals an incentive to take an active interest in the quality and cost of the medical care they receive.

MSAs are the solution to maintaining health care choice while restraining health care inflation. But there is an additional benefit from MSAs that you cannot put a price tag on. By providing a financial incentive for Americans to take an active interest in their health care needs, MSAs will also help to increase American health consciousness, and will encourage Americans to practice even greater preventative care. Let's hope that the House Ways and Means Committee moves quickly to pass the "Family Medical Savings and Investment Act of 1995."

Chairman THOMAS. Thank you, mayor.
Miss Samuelson.

STATEMENT OF JEAN A. SAMUELSON, DIRECTOR OF BENEFIT SERVICES, CORNELL UNIVERSITY, ITHACA, NY

Ms. SAMUELSON. Mr. Chairman and Members of the Committee, I would like to thank you for providing me the opportunity to testify on the Family Medical Savings and Investment Act of 1995.

Chairman THOMAS. Ms. Samuelson, I want to tell you these microphones are very unidirectional so you will have to get it down close to you so we can hear you. Thank you.

Ms. SAMUELSON. At Cornell and through various employee benefits organizations in which I take an active role, we are always looking for the most innovative ways to provide benefit choices to our employees and their families. I began investigating the medical savings accounts for Cornell's employees and will certainly continue to follow this legislation because we want to provide a responsible level of protection in a manner flexible enough to accommodate the needs in today's increasingly diverse work force.

Therefore, we were especially pleased at the approach taken in this legislation. By resisting the temptation to define exactly the benefits available in a medical savings account, you provide the broad freedom of choice that will be most responsive to the largest numbers of employers and their employees.

As the representative of an employer who sponsors a section 125 cafeteria plan, and as a participant in that plan, I believe that this legislation helps employers and employees obtain many of the same goals as flexible health care benefits; Greater individual control and choice in designing plans that meet each individual employee's needs.

Mr. Chairman, we applaud your statement that this bill is a framework awaiting improvement. Already in meetings with staff we have found a willingness to work to resolve problems that arise for particular constituencies. In the end, as these diverse interests bring their creativities to the task, you and the Committee will fashion an even stronger bill. Thus, we support the Family Medical and Savings and Investment Act and also the process you have started to further perfect the bill.

We believe the legislation should go forward and that it will allow cafeteria plans and flexible spending accounts to coexist and augment medical savings accounts. There need be no inherent conflict between medical savings accounts and plans covered under section 125 of the Internal Revenue Code.

I am a board member of the Employers Council on Flexible Compensation, which, coincidentally, has just conducted research into working Americans' attitudes on medical savings accounts. Since 1992, the council has cosponsored Workplace Pulse, the only periodic survey of full-time employed workers.

This most recent Workplace Pulse, which was conducted in early June and released today, found that 85 percent of American workers believe the government does not provide adequate incentives through tax advantages for the average working person to save for future and current health care needs.

Asked specifically whether Congress should create medical savings accounts, a majority of workers support such legislation. By a margin of 56 to 32 percent, working Americans want MSAs. Moreover, participating workers said that if their contributions are tax exempt, they would be willing to contribute as much as $99 monthly to an MSA or $72 if their interest or investment gain were not taxed. Two out of three, 66 percent, said they would participate in medical savings accounts if they were not taxed on the principal or interest accruing in their accounts.

Mr. Chairman, we believe that many of the health care reform proposals put forth last Congress failed to account for the diversity of today's work force and the desire of working Americans to make their own decisions about their health care needs. We believe that the public rejects the "big brother knows best" attitude that has characterized much Federal policymaking in this area and we are encouraged this Congress may pursue creative solutions such as medical savings accounts, solutions that respond to employers' and employees' desires to control their own health care destinies.

[The prepared statement and attachment follow:]

Statement of Jean A. Samuelson
Director of Benefit Services
Cornell University
Before the
Committee on Ways and Means
House of Representatives
June 27, 1995

Mr. Chairman and members of the Committee, I would like to thank you for providing me the opportunity to testify on the Family Medical Savings and Investment Act of 1995, HR 1818. My name is Jean Samuelson, Director of Benefit Services, Cornell University, Ithaca, New York. At Cornell and through various employee benefits organizations in which I take an active role, we are always looking for the most innovative ways to provide benefits choices to our employees. We have investigated the appropriateness of medical savings accounts for our employees and will continue our analysis because we want to provide what is best for our workforce.

Therefore, we were especially pleased at the approach taken in this legislation. By resisting the temptation to define exactly the benefits available in a medical savings account, you provide for the broad freedom of choice that will be most responsive to the largest number of employers and their employees.

As an employer who sponsors a Section 125 cafeteria plan, we believe that this legislation helps employers and employees attain many of the same goals as flexible healthcare benefits--greater individual control and choice in designing plans that meet each individual employee's needs.

We are aware that some believe that HR 1818 will diminish the effectiveness of cafeteria plans. We are also aware that insurers and others who design and administer benefit plans feel threatened by certain provisions of this bill, but we are encouraged that members and staff have exhibited a willingness to work to resolve reasonable issues.

Mr. Chairman, we applaud your statement that this bill is a framework awaiting improvement. Already, in meetings with staff, we have found willingness to work to resolve problems that arise for particular constituencies. In the end, as these diverse interests bring their creativity to the task, you and the Committee will fashion an even stronger bill. Thus, we support the Family Medical Savings and Investment Act and also the process you have started to further perfect the bill.

We believe that the legislation should go forward and will allow cafeteria plans and flexible spending accounts to co-exist and augment medical savings accounts. There need be no inherent conflict between medical savings accounts and plans covered under Section 125 of the Internal Revenue Code.

Several of the organizations that I work with are also investigating medical spending accounts and their appropriateness. I am active in the Tompkins County Health Care Coalition in western New York state. Several of us, employers of various sizes, will be receptive to this legislation.

I am a board member of the Employers Council on Flexible Compensation which, coincidentally, has just conducted research into working Americans' attitudes on medical savings accounts. Since 1992, the Council has co-sponsored Workplace Pulse, the only periodic survey of full-time employed workers.

This most recent Workplace Pulse, which was conducted during the first week of June and released earlier today, found that 85% of American workers believe that the Government does not provide adequate incentives through tax advantages for the average working person to save for their current and future healthcare needs.

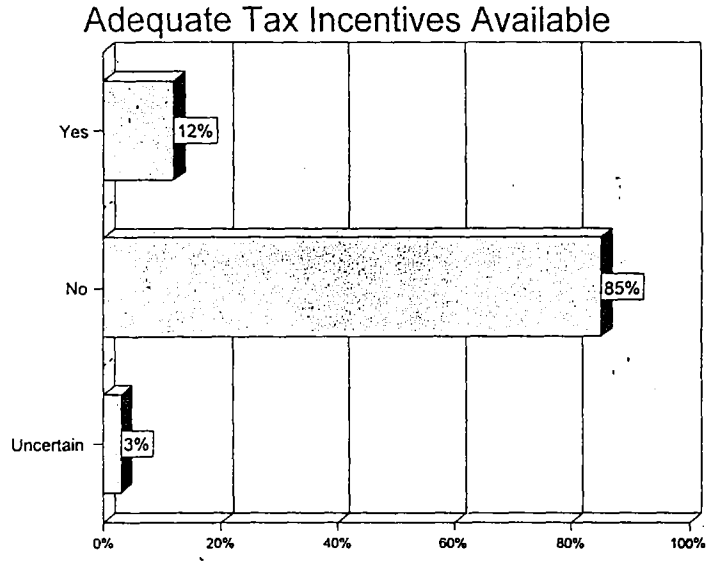
Asked specifically whether Congress should create medical savings accounts, a majority of workers support such legislation. By a margin of 56 to 32 percent, working Americans want MSAs. Moreover, participating workers said that if their contributions are tax exempt, they would be willing to contribute as much as $99.00 monthly to an MSA--or $72.00 if their interest or investment gain were not taxed. Two out of three, 66 percent, said that they would participate in medical savings accounts if they were not taxed on the principal or interest accruing in their accounts.

Mr. Chairman, we believe that many of the healthcare reform proposals put forth last Congress failed to account for the diversity of today's workforce and the desire of working Americans to make their own decisions about their healthcare needs. We believe that the public rejects the "big brother knows best" attitude that has characterized so much federal policy-making in this area. Rather, we are encouraged that this Congress may pursue creative solutions such as medical savings accounts--solutions that respond to employers' and employees' desires to control their own healthcare destinies.

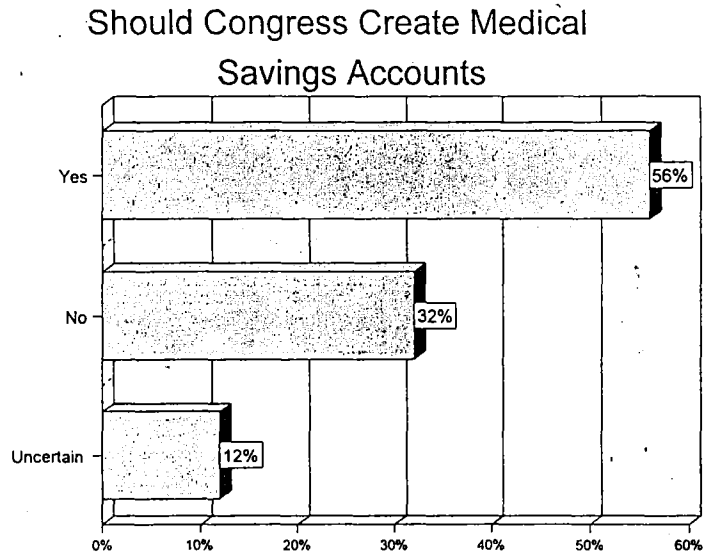
Thank you.

Medical Savings Accounts

As the leading source of employee opinion on workplace benefits issues, Workplace Pulse examined employee opinion on Medical Savings Accounts. Initially, the survey looked at tax advantage incentives to encourage workers to save for health care needs. One question asked: "Do you think the government provides adequate incentives through tax advantages for the average working person to save for their current and future health related needs, yes or no?"



On the subject of Medical Savings Accounts, Workplace Pulse asked: "Congress is considering a new Medical Savings Account that would allow you to have money put aside for current or future medical expenses. This would be somewhat similar to the current Individual Retirement Account, except the money would be set aside to meet medical expenses now and after you retire. Do you think Congress should or should not create this new Medical Savings Account?"



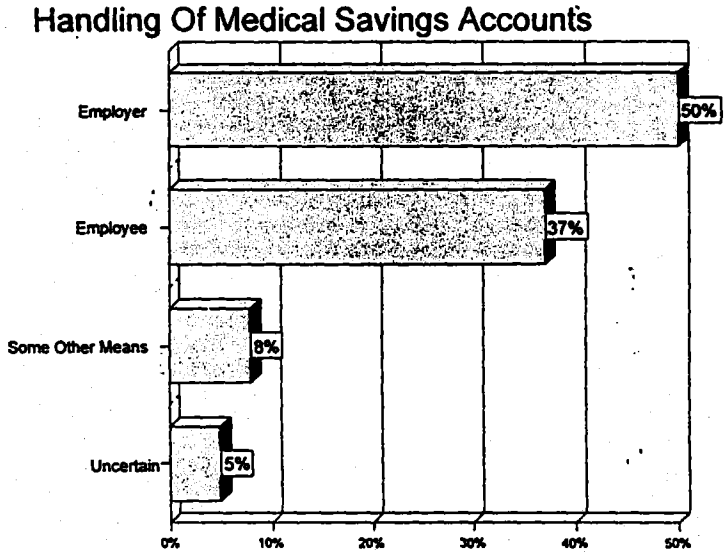
How do working Americans feel about tax advantages which could be associated with Medical Savings Accounts? Workplace Pulse asked: "Congress has not yet decided on the tax advantages associated with Medical Savings Accounts. How much money, if any, would you want your employer to withhold from your salary each month and put in a Medical Savings Account for you under the following conditions? If none, just say so."

- If the money you put in a Medical Savings Account is taxed like your regular earnings, but you do not have to pay taxes on any interest or gain from investments in this account.

- If the money put into a Medical Savings Account is tax deductible just like an Individual Retirement Account where you pay no taxes on the money invested in the account or the earnings from the account.

Employee Participation In Medical Savings Accounts		
	No Taxes On Interest Or Gain	*No Taxes On Money Invested On Interest Or Gain*
Employees Participating	44%	66%
Employees Not Participating	47	26
Undecided Employee	9	8
Average Monthly Investment - All Employees	$35.17	$71.42
Average Monthly Investment - Participating Employees	$72.09	$99.09

A final Medical Savings Account question looked at how these accounts should be handled. Workplace Pulse asked: "Do you think Medical Savings Accounts should be handled through your place of employment where money is automatically deducted each month and your employer handles the paperwork, or would you prefer that Medical Savings Accounts be handled by individuals who can open an account at a local bank or investment firm?"



Chairman THOMAS. Thank you very much, Miss Samuelson.

Next we will hear from Mr. Rateliff, from Wal-Mart, and I understand he is accompanied by an employee or should I say an associate?

Mr. RATELIFF. Associate, yes, sir.

Chairman THOMAS. Associate, Miss Cindy Pierce.

Mr. RATELIFF. I appreciate that.

STATEMENT OF CHARLES R. RATELIFF, SENIOR VICE PRESIDENT, BENEFITS ADMINISTRATION & RISK MANAGEMENT, WAL-MART STORES, INC., BENTONVILLE, AK; ACCOMPANIED BY CINDY PIERCE, ASSOCIATE

Mr. RATELIFF. Thank you for giving us this opportunity to speak to you today. My name is Charles Rateliff and I am senior vice president for benefits administration and risk management at Wal-Mart Stores, Inc., and as you mentioned, with me today is Cindy Pierce. Cindy is an associate from Missouri and I will refer again to Cindy later in my testimony.

Wal-Mart Stores, Inc. is a member of the International Mass Retail Association, a trade association representing the Nation's $282 billion mass retail industry and which collectively employs over a million people.

Our message is very simple and short. We at Wal-Mart have looked at medical savings accounts, or Medisave, carefully and think it is simply an excellent idea. Patient control is at the heart of Medisave. It is our belief that health care consumers will make better health care spending decisions through the freedom Medisave would provide. They will be able to work with their doctors to tailor care to their needs if more of their spending is free of rules and procedures which are necessarily part of health insurance.

Critics of Medisave feel doctors and patients will not be able to make sound health care decisions without the help of institutional managed care. We believe that notion greatly underestimates the American public. For example, Wal-Mart pharmacies answers tens of thousands of inquiries a week from customers who personally pay for their own prescriptions and who are shopping for the best prices.

In the short-term Medisave will give people, that is health care consumers, more control of their health care dollars; give people more insurance options; give people an affordable way to choose higher deductible, lower cost insurance; give people a financial incentive to shop prudently in the medical marketplace, and lead to more affordability in health coverage.

Additionally, in the long run, Medisave will improve doctor-patient relationships by removing insurance-managed care from many health care services, lower health insurance costs, provide a way to pay for long-term care, promote personal savings, and most importantly, lead to a healthier America, which is what we all want.

We have been able to speak to a number of other employers about the Medisave concept. The way we see it, medical savings accounts would be offered as voluntary options to employees funded

by either employer contributions, voluntary employee contributions, or a combination of both.

Medisave is an idea that working men and women of America want and will understand. We have received a number of calls and letters from Wal-Mart associates around the country asking for the kind of help that Medisave could provide. For example, one of our hourly associates, Joi Easterling, had a good idea. Wal-Mart offers four health plans currently with deductibles ranging from $250 to $1,000. Joi switched from the $250 plan to the $1,000 plan and put her biweekly payroll deduction savings in a special savings account. She estimated that her family would soon have enough savings to cover the higher deductible and then some. However, not all people can do what Joi did because of the tax disincentives involved. Joi will have to put aftertax dollars into her savings account. Medisave would level the playingfield and encourage many others to save.

As I introduced Cindy earlier, Cindy has worked in several areas of our company. Cindy is an hourly associate and a young mother who we are happy to report is going to have her second baby soon. Cindy lives in Missouri and gave us this idea in 1994 as an expense savings idea through a program we have, and if I could, I would read it briefly.

She asked us to consider a payroll deduction for the health insurance deductible to be put in a reserve and credited to that associate. Then as each associate incurs claims that will go to the deductible, the amount can be taken from the account and reimbursed to the associate, either by separate check or through their payroll check.

And it is her supervisor, Rose Cooksey, who wrote on here, excellent idea; this would help associates to save money for unexpected bills that would go to the deductible.

Please give Wal-Mart families such as Cindy's the Medisave option. Thank you.

[The prepared statement follows:]

STATEMENT OF CHARLES R. RATELIFF, SENIOR VICE PRESIDENT, BENEFITS ADMINISTRATION AND RISK MANAGEMENT, WAL-MART STORES, INC.

Thank you for giving us an opportunity to speak to you today.

Wal-Mart, Stores, Inc. is a member of the International Mass Retail Association, a trade association representing the nation's $282 billion mass retail industry, and which collectively employs over a million people.

Our message is very simple. We at Wal-Mart have looked at Medical Savings Accounts or medisave, carefully and believe it is simply an excellent idea.

Patient control is at the heart of medisave. It is our belief that health care consumers will make better health care spending decisions through the freedom medisave would provide. They will be able to work with their doctors to tailor care to their needs if more of their spending is free of the rules and procedures which are necessarily part of health insurance.

Critics of medisave feel that patients and doctors won't be able to make sound health care decisions without the help of institutional managed care. We believe that notion greatly underestimates the American public. For example, Wal-Mart pharmacies answer tens of thousands of inquiries a week from customers who personally pay for their own prescriptions and who are shopping for the best prices.

In the short-term medisave will:

- Give people -- health care consumers -- more control of their health care dollars,
- Give people more insurance options,
- Give people an affordable way to choose higher deductible, lower cost insurance, and
- Lead to more portability in health coverage.

Additionally, in the long run medisave will:

- Improve doctor-patient relationships by removing insurance "managed care" from many health care services,
- Lower health insurance costs,
- Provide a way to pay for long term care,
- Promote personal savings, and most importantly,
- Lead to a healthier America, which is what we all want.

We have been able to speak with a number of other employers about the medisave concept. The way we see it, medical savings accounts would be offered as voluntary options to employees, funded by either employer contributions, voluntary employee contributions, or a combination of both.

Medisave is an idea the working men and women of America want and will understand. We have received a number of calls and letters from Wal-Mart associates around the country asking for the kind of help medisave would provide.

One of our hourly associates, Joi Easterling, had a good idea. Wal-Mart offers four health plans with deductibles ranging from $250 to $1000. Joi switched from the 250 plan to the 1000 plan and put her bi-weekly payroll deduction savings in a special savings account. She figured out that she and her family would soon have enough savings to cover the higher deductible and then some. However, not all

people can do what Joi did because of the tax disincentives involved. Joi will have to put after-tax dollars into her savings account. Medisave would level the playing field and encourage many others to save.

Another associate with a good idea is Cindy Pierce, who is with me today. Cindy is an hourly Wal-Mart associate and a young mother who we're happy to report is going to have her second baby soon. Cindy, who lives in Missouri, gave us this in 1994 as an expense savings idea. Let me read it:

> Consider a payroll deduction for the health insurance deductible to be put in a reserve and credited to that associate. Then as each associate incurs claims that will go to the deductible, the amount can be taken from the account and reimbursed to the associate, either by separate check or though their payroll check.

Her supervisor wrote:

> Excellent idea! This would help associates to save money for unexpected bills that would go to deductible.

Please give Wal-Mart families such as Cindy's a medisave option.

Thank you.

Chairman THOMAS. I thank the panel very much, and the gentleman from Louisiana wishes to inquire.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Rateliff, you offer four different kinds of health insurance packages?

Mr. RATELIFF. Yes, sir.

Mr. MCCRERY. Approximately how many of your employees are covered by the high-deductible choice?

Mr. RATELIFF. The highest deductible? We have a—let me briefly explain—$250, $500, $750, and $1,000. There is about 8 percent in the thousand dollar coverage.

Mr. MCCRERY. And is that what you—is the thousand dollar deductible what you would describe as your MSA account?

Mr. RATELIFF. No, sir. We have not designed an MSA account, per se. That example was one of our associates that chose that route. She didn't know what to call it but she chose that as a way to save premiums, set the money aside and use it as she needed it.

Mr. MCCRERY. So, do you see more employees moving to higher deductible policies; is that a trend in your company?

Mr. RATELIFF. Yes, sir, we offered these—we just began offering these about 3 years ago. We had lower deductibles. We began offering multiple options and this is exactly what we have seen, associates like Joi that have moved up to higher deductible levels and reduced their premium costs and saved the difference.

Mr. MCCRERY. And what has been the experience with your company in terms of your overall health care costs?

Mr. RATELIFF. This last year we had—we are a self-insured plan, which the company pays about two-thirds of the cost, and our plan was flat. We had no premium rate increase this year.

Mr. MCCRERY. Is that unusual?

Mr. RATELIFF. Very unusual.

Mr. MCCRERY. Ms. Samuelson, if MSAs are made tax deductible, put on the same basis as any other health insurance vehicle, do you think that insurance companies will go out of business or will they adapt to the change, and create new insurance products? What is your opinion on that?

Ms. SAMUELSON. I do not think they will go out of business. I think they will start marketing more catastrophic health insurance policies. Cornell is a self-insured employer, so I am not sure I am adequately representing the view of insurers, but New York State insurers have an advantage already.

Mr. MCCRERY. Well, I happen to agree with you. I think the insurance industry will adapt rather readily to the concept of MSAs and begin to offer a variety of vehicles to employers who are not self-insured and to the marketplace in general.

Mr. Chairman, those are all the questions I have of this panel.

Chairman THOMAS. I thank the gentleman. The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman.

Mayor, a couple of questions. First of all, if we apply this to the Federal employees, do you think that we will have similar numbers of people signing up? And a lot of people have talked about the risk

selection. With the large amount that we get to potentially sign up, do you think we would have problems with risk?

Mr. SCHUNDLER. I think you would get large amounts to sign up. I think your experiences would be similar to my own. You would achieve immediate savings. You would find some people, just by virtue of not paying attention, would keep whatever they are choosing now. And those who are paying attention would probably switch immediately. The next year, after you sent the checks out, you would see most of your people switch.

I do not think you would see adverse selection. As was testified by someone earlier, I think, if anything, those who are concerned because they know they have health problems and they know they are going to be seeing a doctor, they may well have already been—Because if they have seen a lot of doctors, they may already know who they trust and those who they do not, so they are the most averse toward going into an HMO. They want to go to a doctor because they know they have a real problem.

So, if anything, you will see a lot of people going into it who, in fact, are more unhealthy, but that still gives them an incentive to try to get the best deal. Again, it reduces their out-of-pocket expense when they go into the MSA versus staying in the current policy. It also gives them the ability to stay with the doctor they want. But, if per chance it should be a good year, they are going to be directly getting money back, and that is a good thing. They are going to want to get their health care costs under control.

Mr. ENSIGN. Could you address any potential conflicts? Are there any with 1818 and the current State law that you know of?

Mr. SCHUNDLER. No, not at all, not at least in New Jersey.

I want to point out the provider we have offering the MSA to us is actually Blue Cross/Blue Shield of New Jersey, who manages the State plan. So, we directly went to the provider who is already providing the three options we had. We asked them to create a fourth for us. The State gave us explicit permission to go and to pilot it for the State's benefit, to offer a fourth option, and most employees are extremely happy and the insurance company was able to adapt very quickly.

Mr. ENSIGN. Thank you.

Ms. Samuelson, right now 1818 single taxpayer can deduct up to $2,500 annually. Do you think the bill would be more effective if the individual was allowed to deduct, say, $2,000 initially and then increase to $3,000, say over like a 7-year period? Do you think that would make the bill any better?

Ms. SAMUELSON. I do not know. I do not see what effect that would have on it. At least this way it is consistent with the dependent care accounts.

Mr. ENSIGN. OK. Mr. Rateliff?

Mr. RATELIFF. Rateliff.

Mr. ENSIGN. OK. Mr. Rateliff, based on Wal-Mart's experience with MSAs and your employees, long-term do you see this being an effective alternative? Do you think over the long term—we get some of these switches, like maybe up to 90 percent in the first couple of years. Do you think long-term employees will stay with it?

Mr. RATELIFF. We have no experience with it yet. We are just studying it. And yes, we do believe long term that they will make that conversion. We are getting too many cards and letters and phone calls from associates that are asking to have those sorts of options. They may not know—they do not call it Medisave or medical savings accounts.

Mr. ENSIGN. What do you think long-term it will do to your administrative costs?

Mr. RATELIFF. That is a good question, too. Our costs currently run about 3 percent. We felt like if we could cut those in half, I think that is hard to estimate at this time, it would save us about $7 to $8 million corporately. Since we are self-assured, we would pass that back to lower premiums in the plan.

If I might address the previous question to Ms. Samuelson, we believe a higher deductible option later on, having seen the patterns we have seen so far of folks wanting higher deductibles, would be something they would want. They would like to accumulate the money and move into a high-deductible, be able to continue to reduce their premiums long term. We would like to see that.

Mr. ENSIGN. Very good. Thank you, panel, and thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman. Let me thank all our witnesses for their testimony. It is very helpful to us.

Mayor Schundler, I am impressed by the results you have been able to accomplish in Jersey City. It is very impressive the type of savings you have been able to achieve for your taxpayers as well as providing additional incentives for your employees.

When was that plan put into effect?

Mr. SCHUNDLER. This January.

Mr. CARDIN. So, you have just 6 months of experience?

Mr. SCHUNDLER. Right.

Mr. CARDIN. At the present time. If I understand it, you offer your employees a choice. They can get the identical benefit structure, the only difference being the deductible and copay.

Mr. SCHUNDLER. That's right.

Mr. CARDIN. And they can choose to go into the medical savings account plan or go into the traditional plan.

Mr. SCHUNDLER. Lower deductible plan.

Mr. CARDIN. Right. What has been the experience? What is the percentage difference?

Mr. SCHUNDLER. Fifty-six percent have chosen the MSA in the first year. Again, I am convinced after the checks go out in December, we will see more switch into it.

Mr. CARDIN. Have you noticed any trend as far as the age of the employee or the health history of the employee as to which ones are choosing which plans?

Mr. SCHUNDLER. No, I honestly have not studied that, so I cannot answer it.

I think, again, one of the things we were able to do for our employees that was charted out for them, what the impact would be on them if they had high costs or low costs. They benefit under either scenario with the MSA.

There is only one place where you actually are a little worse off, and that is if you have costs which are right about the deductible level. If your costs are, for instance, $2,000, because your MSA contribution is taxable income to you, it actually is marginally less attractive. But that is a very narrow band, between about $1,800 and $2,200 of expenses where you lose out. And you lose out only slightly.

If you pass this, that will even—that band will be eliminated, and it will be more attractive for the employee. And it is much more attractive when your costs are much higher or much lower.

Mr. CARDIN. You are estimating a $500 per family savings for the taxpayers.

Mr. SCHUNDLER. That is in pocket now.

Mr. CARDIN. Pardon?

Mr. SCHUNDLER. That is in pocket now. Because our premiums immediately went from $6,800——

Mr. CARDIN. That is the question I wanted to ask. You have achieved that through your——

Mr. SCHUNDLER. That is already achieved. We think the—the premium already went from $6,800 to $4,500 because the deductible went up. But as the claims experience goes down, then we think you will see further premium reductions in the next couple of years. And, ultimately, when it begins to go up farther into the future because of inflation and so forth, it will go up more slowly. And the experience we have had, actually the premiums for the standard plan doubled in just the last 5 years.

Mr. CARDIN. If the Federal legislation prohibited the annual withdrawal of the funds for the employee but required that they be accumulated for health reasons or to reach the age of retirement or the age of when it is permitted under IRAs to withdraw funds, would that have, in your view, a negative impact on your plan?

Mr. SCHUNDLER. I think so. I think it would have—monies tomorrow are less attractive than moneys today. So, I think that takes away some of the incentive that we want to create for people to shop around for quality and cost.

Mr. CARDIN. Well, thank you very much, and I would appreciate it if you would keep us informed if you find out some of the demographics as to who chooses which plans. They may be useful to us.

I know the underlining insurer is doing that and if we could get that information it would be certainly useful to us in our analysis.

[The following was subsequently received:]

City of Jersey City - MSA Pilot Program

MSA Participant Profile

Average age: **42.2yrs.**

72% are **male**
28% are **female**

61% are **married**
36% are **single**
4% are **divorced**

37% have **coverage 10**(Employee Only)
22% have **coverage 40**(Employee and Spouse)
36% have **coverage 50**(Employee and Family)
5% have **coverage 80**(Employee/Child/Children)

City of Jersey City
Bret Schundler, Mayor

MEDICAL SAVINGS ACCOUNT (MSA) PILOT PROGRAM

Employee Census (3/1/97)

	MSA
Employee Only:	49
Employee/Spouse:	25
Employee/Family:	43
Employee/Children:	7
Total:	124 (56%)

	Traditional
Employee Only:	24
Employee/Spouse:	24
Employee/Family:	13
Employee/Children:	2
Total:	63(29%)

	Blue Choice (POS)
Employee Only:	6
Employee/Spouse:	3
Employee/Family:	15
Employee/Children:	3
Total:	27(12%)

	HMO Blue
Employee Only:	2
Employee/Spouse:	1
Employee/Family:	3
Employee/Children:	1
Total:	7(3%)
GRAND TOTAL:	221

Note: Page 108:(Lines 2473 - 2476)
Page 113:(Lines 2565 - 2567)

Chairman THOMAS. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. I just wanted to ask Mrs. Pierce, as an associate of Wal-Mart, what have you felt to be the general feeling of the associates? Have they been very satisfied thus far? What has been your general experience personally as well as your representation of the other associates at Wal-Mart?

Ms. PIERCE. On this plan?

Mr. CHRISTENSEN. Yes.

Ms. PIERCE. We have not really even——

Mr. RATELIFF. Again, we have not instituted an MSA. We have no experience.

Mr. CHRISTENSEN. Do you feel that there will be a general acceptance by a lot of the associates for that?

Ms. PIERCE. Oh, definitely. Yes, I do.

Mr. CHRISTENSEN. I wanted to ask Mayor Schundler, why do you favor an MSA over managed care? And maybe you could delineate a little more specifically why you think an MSA may be a better alternative to go than a managed care system?

Mr. SCHUNDLER. I think what managed care does ultimately is third party rationing. It is not as good to say that if you do something bad to yourself, we will make it all well again, than if you can say to someone, we will give you an incentive not to do something bad to yourself.

So, you naturally have inflation when people are in managed care systems because people are still going out and not doing preventive care. They have no incentive necessarily financially. So, what ends up happening is, the way you begin to control costs in a managed care system is by reducing benefits or by increasing employee copay. That is the only way you will really begin to reduce costs in the long term.

I think it is far better to focus on preventive care, responsible action, and on consumer shopping around. And that is the way to really control health care costs without having to take away benefits.

Mr. CHRISTENSEN. I Really appreciate your leadership in these areas as well as all the other areas you have been leading in. I think we look forward to maybe taking it one step farther and adding a little bit of a Federal slice to this MSA with an amendment. So, thank you so much for your leadership.

Mr. SCHUNDLER. Congressman, if I could add one point?

Mr. CHRISTENSEN. Yes.

Mr. SCHUNDLER. I think you would also see the Treasury benefit immediately. Because, again, since health care costs are an exclusion and our total exclusion now goes from $6,800 to—again, we are not taxable to begin with. But say we were a corporation, our costs would go from $6,800 to $6,300. That is $500 more per family member you would be able to tax.

I might add that the rebate under the Archer plan is taxable income also. So, you would be able to tax that also. You would have an immediate positive impact not only if you extended it to your employees, but for everybody else who uses it. There would be more money for government to tax unless there is an exclusion.

Mr. CARDIN. If whoever has the time would yield?

Chairman THOMAS. The gentleman would be happy to yield.

Mr. CARDIN. If I could ask one more question, mayor, if I might. The premiums for those individuals who are not in the MSA option, has that premium changed at all?

Mr. SCHUNDLER. No. Well, no, it has not changed with the exception of it went up with the regular State plan. There has been no adverse effect, in short.

Mr. CARDIN. You were paying $6,300.

Mr. SCHUNDLER. $6,800 on that plan.

Mr. CARDIN. And that is still at $6,800. You have not achieved savings in the plan like you have in the MSA option?

Mr. SCHUNDLER. That is correct.

Chairman THOMAS. But it has not gone up, either.

Let me underscore the gentleman from Maryland's request about information, mayor. You have only been in the program, I understand, 6 months, so, obviously, we would be very interested.

As you may have heard from other panelists, some of the criticism is there is an adverse selection process. And it just seems to me that if you have any data on the initial selection—I assume you did some advertising and across the board in materials of the city employees.

Mr. SCHUNDLER. Right.

Chairman THOMAS. Have you done any analysis at all as to who jumped at the opportunity to utilize the MSA?

Mr. SCHUNDLER. Again, I apologize I cannot give you good information. Anything I would bring to you today would be conjecture. My employees——

Chairman THOMAS. We would be very anxious if you would analyze the profile. It is of great concern to us and we would appreciate having some empirical data.

[The information was not available at time of printing:]

Chairman THOMAS. What about the other cities in New Jersey? As you move around to various city organization, have you gotten some inquiries? How large is Jersey City?

Mr. SCHUNDLER. Two hundred thirty thousand people. We have about 2,500 employees.

Now, we were the first—we were the first to do this. There have been a lot of cities leaving the State plan because of the dramatically rising premium costs to being in the State plan. As you might imagine, there has been a lot of union opposition, because typically what the cities have done as they leave the State plan they may actually try to get copayments or what have you from their employees. So, it creates a lot of fractiousness.

Instead of leaving the State plan, we went to the State and said, give us permission to add an alternative that will allow us to achieve the savings we are interested in and it will make our employees very happy and feel secure.

Chairman THOMAS. Thank you.

And, obviously, Mr. Rateliff, Wal-Mart has a significant number of employees. What percentage of the employees of Wal-Mart are hourly associates?

Mr. RATELIFF. About 85 percent.

Chairman THOMAS. About 85 percent. That would translate into how many numbers, roughly? Ballpark.

Mr. RATELIFF. Well, we have 600,000 on the payroll totally.

Chairman THOMAS. The two examples you gave us of folks who were prescient enough to ask for this without knowing the name of it were in fact both hourly associates?

Mr. RATELIFF. Yes, sir.

Chairman THOMAS. If you do initiate any program like this, once again we would appreciate having any data that you have in materials of age or income groups or other discernible categories who see this perhaps as an option more than other categories. We think it will be a definite plus as an additive. Some folks see it as a panacea. I believe a number of folks testified today that as an additive it certainly is an attractive option.

Mr. RATELIFF. That is correct.

Chairman THOMAS. I have been urged by several of my colleagues to go ahead and move the bill today. This is a hearing, not a markup, but I can assure you that sentiment expressed on both sides of the aisle is largely in support of this concept. I just hope we can quit talking and move the product.

I want to thank you very much for your testimony, once again, indicating to Congress that things are going on in the private sector, Mrs. Samuelson, among State institutions, among cities, and among the private sector, and it is time that Congress caught up to the ideas that are out there. Thank you very much.

This hearing is adjourned.

[Whereupon, at 1:25 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION FOR THE RECORD ON MEDICAL SAVINGS ACCOUNTS AND THE "FAMILY MEDICAL SAVINGS AND INVESTMENT ACT OF 1995, H.R. 1818"

The American Dental Association (ADA) is very pleased to have an opportunity to submit this statement for the record on the issue of Medical Savings Accounts (MSAs). The Association is the largest dental organization in the United States, representing more than 140,000 dentists.

The ADA enthusiastically supports H.R. 1818, the "Family Medical Savings and Investment Act of 1995", introduced by Chairman Archer (R-TX) and Representative Jacobs (D-IN), which offers consumers the option of managing their own insurance program through medical savings accounts.

MSAs are a market-friendly means of controlling medical health care costs by reducing demand for unnecessary medical services. The advantages of MSAs are clear: they empower and motivate individuals to seek only necessary, cost-effective care because consumers will be using their own money. At the same time, freedom of choice of providers is guaranteed; and the insurance is portable because it belongs to the individual, thus addressing the "job lock" issue that has been one of the major concerns of health care reformers. MSAs can even increase coverage because they can be used to cover services which may be important to the individual, but which are not usually covered under more traditional insurance.

Further, like millions of Americans, many dentists are self-employed and may take only a 25 percent (30 percent beginning in 1996) deduction for premium payments for their health coverage. This is a long-standing inequity ameliorated with MSAs.

The ADA commends the Chairman for his leadership in developing an alternative insurance proposal as part of health system reform that emphasizes equity, efficiency and individual responsibility.

H.R. 1818 permits an "eligible" individual to deduct annual contributions to a Medical Savings Account (MSA) totaling the lesser of $2,500 or the deductible under a catastrophic health plan. The contribution ceiling is raised to $5,000 if the catastrophic plan also covers a spouse or dependent. To become "eligible" for an MSA, an individual is limited to catastrophic health plan coverage, except for certain "permitted coverage" including dental care only plans.

The bill defines catastrophic health plans as any health plan that provides no compensation for expenses covered by the plan until the expenses exceed $1,800 for an individual or $3,600 if the plan covers more than one person. However, exceptions to this deductible provision are allowed for "permitted coverage," including plans furnishing coverage only for dental care. Withdrawals from an MSA are excluded from income if they are used for "qualified medical expenses" for medical care as defined in

section 213(d) of the Internal Revenue Code, which includes dental care. Long-term care insurance and catastrophic health plan coverage may also be purchased with MSA funds.

Employer-provided coverage under an accident and health plan may continue without such contributions being taxed as gross income to employees. Employers will also be able to continue to exclude such contributions from employment taxes.

Dental Benefits and MSAs

The ADA supports the use of MSA funds for dental service expenditures not covered by dental benefit plans. Oral health is an essential part of total health care. Many medical conditions are self-limiting, but dental diseases are chronic, progressive and destructive, becoming more severe over time. Dental disease, however, is almost entirely preventable with regular examinations. The ADA believes that MSAs are an excellent opportunity for those with no or inadequate dental coverage to better access the dental delivery system.

It is essential, however, that MSAs remain an option and not a substitute for employer-provided free-standing dental insurance that is tax deductible for the employer and excluded from employees' income. Twelve million Americans had dental coverage in 1970, by 1992 that number expanded to 110 million. From 1980 to 1992 the percentage of school children free of tooth decay increased from 37 to 50 percent. This success is attributable, in part, to the increased access to care afforded through the availability of dental plans. Most dental benefit plans fully cover services that prevent disease. Significantly, the National Institute of Dental Research estimates that Americans saved nearly $100 billion in dental care bills during the 1980s because of dentistry's emphasis on preventive oral health measures. The Association believes that it would be contrary to sound public policy to undermine the current cost-effective dental benefit system by taxing those benefits.

The Association notes that some MSA proposals restrict individuals who elect the MSA option to high-deductible medical benefit plans. The ADA understands the rationale for such a restriction as it applies to medicine, but believes it is unnecessary and inappropriate to apply such linkage to dental benefit plans.

Standard dental benefit plans have historically required significant beneficiary cost-sharing through copayments, deductibles and limits on the type and frequency of care, and they invariably use annual maximums. As a result, the dental patient with dental coverage is already sensitized to the cost of dental treatment. Indeed, currently about 50 percent of all

dental expenditures are out-of-pocket, while only about 20 percent of medical costs are directly borne by the patient.

The CATO Institute, long a proponent of medical savings accounts, in its March 14 policy analysis, implicitly supports the Association's proposition that dental benefit plans already strike a proper balance between patient and third-party responsibility. According to the analysis, cost increases have risen less rapidly for services characterized by lower third-party payments. For example, from 1965 to 1990 inflation-adjusted increases for hospitalization costs rose 350 percent and physician costs increased by 250 percent, but dental costs rose only 200 percent. In addition, "From 1960 to 1990 out-of-pocket health spending relative to personal income did not increase at all. Yet total health care spending relative to income tripled during that period."

Further, linkage of dental coverage to a catastrophic plan is also inappropriate. Medical benefit plans are inherently different from dental plans. All medical benefit plans are, first and foremost, intended to provide insurance against catastrophic events that could bankrupt the average family. Consequently, even high-deductible medical coverage serves the primary purpose of medical coverage and, when linked with an MSA, provides many individuals with appropriate incentives to cut costs.

On the other hand, dental expenses are not catastrophic in nature. In fact, the standard dental benefit plan is really not an insurance plan at all, but a prepayment plan. First dollar coverage in dental plans is invariably limited to preventive and diagnostic services. Patients who require more extensive and costly care must bear an increasingly greater share of the cost. At the same time, most dental plans reimburse preventive services at 100 percent of costs because prevention is such a integral, cost-effective component to good oral health.

A high-deductible dental benefit plan, which would not reimburse until a threshold amount is reached, would preclude payment of preventive services for most people. Even on the surface, this appears "penny wise and pound foolish" as a cost-control mechanism in dentistry because it merely defers treatment, and, therefore, will increase the eventual cost of dental care. Individuals who choose to avail themselves of the MSA program must not be required to settle for a dental coverage plan that fails to cover preventive services at 100 percent. To require otherwise would be a clear step backward for the approximately 110 million Americans with dental coverage and would support the contention of MSA opponents that medical savings accounts undermine preventive care efforts.

The Association believes its reading of H.R. 1818, which permits individuals (or employers on behalf of employees) to continue to purchase dental only coverage with pre-tax dollars while participating in the MSA option, indicates that this bill supports the ADA's position that the integrity of free-standing dental plans must not be threatened.

In closing, Mr. Chairman, the Association is very pleased to be given an opportunity to comment on H.R. 1818. The ADA believes it is an outstanding bill that takes the proper approach toward health care cost containment -- the establishment of a system with market-based incentives to empower individuals to make wise health care purchasing decisions.

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

RE: Medical Savings Accounts and the "Family Medical Savings and Investment Act of 1995, H.R. 1818"

June 27, 1995

Mr. Chairman and Members of the Committee:

The American Medical Association (AMA) appreciates the opportunity to submit this statement for the record regarding the "Family Medical Savings and Investment Act of 1995," and to express our overwhelming support for the passage of medical savings accounts (MSA) legislation by this Congress.

We commend Chairman Bill Archer and Representative Andrew Jacobs for their leadership in introducing this legislation. MSAs, combined with catastrophic insurance coverage, represent a refreshing and rational reform of our health delivery system. Empowering individuals with the ability to choose the type of health care they will purchase and from whom has continued to remain at the center of the health reform debate: Should we favor more government control over our health care dollars or more freedom for all of us as consumers of health care to make our own decisions? The answer from the American people is clear, and the Archer-Jacobs MSA legislation will help to provide health care consumers with that freedom.

For almost a decade, the AMA has been on record as supporting the adoption of MSAs as an option in our health care system. In fact, a longtime AMA health policy economist, Jesse Hixson, PhD, is credited by the National Center for Policy Analysis (NCPA) with the original concept of medical savings accounts. We believe MSAs not only represent a cost effective approach to providing health care, but also strengthen the market for medical care by assuring patients more freedom of choice.

We understand that the Archer-Jacobs legislation would allow individuals to establish a medical savings accounts in conjunction with a catastrophic health policy. Such catastrophic health plan would be a plan that has a deductible amount of at least $1,800 for an individual or $3,600 if the plan provides coverage for more than one individual.

Within certain limits as described in the Archer-Jacobs legislation, employer contributions would be excludable from gross income if made by the employer and deductible if made by the individual. The amount of individual contributions that could be deducted or employer contributions that could be excluded for a taxable year would be the lesser of either the catastrophic health plan's deductible, or $2,500 per individual or $5000 if the MSA covers a family. Withdrawals from a MSA would be excluded from income if used for qualified medical expenses for the individual or family.

There are many advantages to using MSAs and the AMA would like to touch on several reasons we believe the Archer-Jacobs bill would be beneficial to our health care delivery system.

The Advantages of MSAs

MSAs are cost-effective. A fundamental problem exists today in the way we finance our health care. Because many of us receive our health care insurance from an employer-provided plan, we do not personally feel the need or the desire to pay attention to the cost of a medical procedure. With traditional insurance, consumers are insulated from prices and do not perceive the full cost of consuming health care resources. Numerous studies provide evidence that third party payment for health care shields patients from cost awareness and the responsible consumption of health care dollars. In fact, a Rand Corporation study found that individuals who had access to "free care" consumed at least 30 percent more than those who had to pay a substantial portion of the bills up to a maximum amount out-of-pocket.

One might ask a simple question: Is it more desirable to link the patient to the cost of health care or insulate the patient from the cost? Unfortunately, the lack of this direct linkage has led to systematic overuse by consumers who have had little incentive to limit spending or thoughtfully weigh the cost/benefits of services. Consumers are not exerting as much pressure on providers for economic efficiencies as they would if they were paying the full cost of medical care directly out of their own pockets. The result is that many prices may be higher than they otherwise would be and many providers are less efficient than they could be.

MSAs will spur much needed competition in the health care marketplace. MSAs as contained in the Archer-Jacobs bill represents a market approach, rather than a regulatory approach, to reducing health care costs by encouraging prudent health care buying and saving. Rather than achieving cost containment through global budgeting or price controls, which usually leads to gaming or other distortions in the health care system, the AMA believes the Archer-Jacobs bill would create incentives to wisely use one's own health care dollars, rather than continue the present perverse incentives to freely consume someone else's.

Companies searching for more innovative and cost-effective ways to provide health care benefits for their employees have learned first-hand the benefits of putting employees in control of their health care dollars through the use of MSAs. It has been reported that *Forbes* magazine health costs fell 17 percent in 1992 and 12 percent in 1993. Likewise, in the first year of a MSA plan for its employees, health costs for Golden Rule Insurance Company were 40 percent lower than they would otherwise have been. Dominion Resources and Knox Semiconductors, two northeast companies, have had virtually the same experience with their MSAs -- the cost of the premiums for their employee's health insurance fell significantly.

Further, by allowing unspent balances in MSAs to be carried over to subsequent years as set forth in the Archer-Jacobs bill, consumers will be rewarded for practicing responsible consumption. We believe it is more desirable to reward health care consumers for using the system cost effectively rather than punishing them for not using the system in a cost effective manner. By encouraging appropriate use of our nation's health care dollars, while preserving individuals' access to the physicians and plans of their choices, MSAs as contained in this legislation, represent one of the best approaches to achieving cost savings in a competitive environment.

We believe the Archer-Jacobs bill would have the capacity to increase portability of health care policies, a goal which has broad bipartisan support. The portability aspect of MSAs will enhance job mobility by eliminating "job-lock" that forces many employees, especially those with pre-existing conditions, to stay in jobs in order to continue receiving needed coverage. Indeed, recent public opinion surveys conducted by the Employee Benefit Research Institute in conjunction with The Gallup Organization found that one in five Americans surveyed indicated they or a family member passed up a job opportunity based solely on health benefits.

In addition, MSA funds could provide financial resources for workers who become temporarily unemployed, allowing them to purchase bridge health insurance while they are between jobs. According to the NCPA, a leading advocate of MSA legislation, of the 37 million Americans who are uninsured this month, more than 50% will be insured four months from now. More than 70% will be insured within one year. While the greater availability of MSAs will not completely solve the portability problem, they could result in greater access to our health delivery system.

Improving the Doctor-Patient Relationship

By giving consumers the ability to make their own decisions about the value of the health care they will purchase, we believe the Archer-Jacobs bill has the potential for substantially improving the physician-patient relationship, a relationship which has eroded by the increasing intrusion of third party payors. Unlike some traditional health benefit plans which "manage" care by limiting access through plan restrictions, MSAs would eliminate the need for bureaucratic restraints that interfere with patient choice and the patient-physician relationship. As recognized by the NCPA, patients and doctors would be encouraged to manage the care -- not a third-party payor. Moreover, MSAs would empower patients to make prudent and sensible treatment choices, and reap the reward of their savings. Savings accrued by more cost conscious purchasing of health care would accrue to the patient, not to the HMO or some other third party payor. Most important, MSAs would allow the individual -- not a third party -- to choose the physician, plan, treatment, and range of services that best meet his/her needs.

The Archer-Jacobs legislation would provide a responsible way to pay for future health care expenses including long term care costs. MSAs have unlimited potential in our health care system. From the private sector to Medicare and Medicaid, MSAs are a viable option in the health care marketplace as well as an important savings mechanism for future undetermined medical expenses.

MSAs and Medicare Transformation

The AMA fervently believes that the Medicare program must be transformed. An important component of this transformation should be the availability of MSAs as an option for Medicare beneficiaries to choose as we recognize is envisioned in the Archer-Jacobs legislation. We believe that each Medicare beneficiary should have an expanded set of choices that range from the restructured traditional Medicare program to various health plans to Medical Savings Accounts. A Medicare Medical Savings Account option should be funded by a defined government annual contribution with the requirement that part of these funds be applied toward purchase of a high-deductible, catastrophic insurance policy each year. The AMA would advocate that contributions to the MSA in the amount of the value of the government contribution amount be exempt from federal and state income taxation. Further, we believe distributions from a Medicare MSA should be tax advantaged if used for medical expenses, catastrophic health insurance premiums or long term care premiums as also foreseen in the Archer-Jacobs MSA bill.

The AMA strongly favors Medicare MSAs because of their potential to enhance the operation of the medical care market, to promote competition between health care providers, and to temper the rates of price inflation of medical services. Exercising greater choice may increase the complexity of the beneficiary's decision-making about medical care, but it will undoubtedly provide enhanced opportunities for more prudent use of medical care resources.

There have been several criticisms of MSAs, a few which the AMA would be pleased to address from a physician's viewpoint. It has been argued that MSAs like those proposed in the Archer-Jacobs legislation are likely to reduce incentives to seek preventive medical care. We disagree. The AMA has long advocated the importance of preventive medicine from routine checkups for kids to mammograms and prostrate screenings for adults. We are aware of no long-term studies to support the contention that MSAs are likely to discourage individuals from seeking preventive medical care. In fact, MSAs could be a source of funds for services such as preventive care not always covered by traditional health insurance. Moreover, anecdotal evidence from employers suggests that employees are most interested in seeking preventive care including wellness programs to avoid greater health risks and costs down the road.

It has also been argued that MSAs are not likely to reduce costs because consumers are not in a position to bargain for reductions in costs as are managed care plans and insurance companies. This argument overlooks the fact that a significant number of employee benefit plans are self-insured. While many of these plans contract with insurers as third party administrators, such plans are increasingly recognizing that direct contracting with physician groups can avoid insurance costs. Further, consumers can and will make prudent decisions about their health care just as they decide the type of mortgage to purchase, the kind of car to buy or the amount of life insurance to carry. As Thomas Sowell wrote during the health care reform debate last year,

"No freedom can be more personal than to decide for yourself what should be done to preserve your health and your life."

Recognizing the importance of preserving patient choice in health care, a number of states have recently passed measures authorizing the use of tax-free MSAs for medical expenditures. As a result, there is now an increased availability of MSAs, usually combined with high deductible, catastrophic health plans. To date, at least eleven states have enacted MSA laws including Arizona, Colorado, Idaho, Illinois, Michigan, Mississippi, Missouri, New Mexico, Utah, Virginia and West Virginia.

On the Federal level, the 103rd Congress produced a number of proposals incorporating MSAs, with over 200 bipartisan House and Senate supporters. Legislation introduced so far this year demonstrates the continued enthusiasm on both sides of the aisle for MSA legislation.

As the dog days of summer wear on, the AMA believes it is time for the United States Congress to step up to the plate and hit a home run for patients, physicians and, in short, our health care system by passing sound and sensible MSA legislation such as the Family Medical Savings and Investment Act of 1995.

Mr. Chairman, we are grateful for the opportunity to share our thoughts with you. The AMA looks forward to working with you, Chairman Archer, Representative Jacobs and the Congress as this important legislation moves forward.

Testimony to the House Ways & Means Committee
Health Subcommittee Hearing on Medical Savings Accounts
June 27, 1995

By John Burry, Jr.
Chairman and Chief Executive Officer of Blue Cross & Blue Shield of Ohio
Chairman of Mountain State Blue Cross & Blue Shield

The 104th Congress has committed itself to reforming the way health care is financed in America. The Ways and Means Committee, in particular, is to be commended for taking on the two most fundamental issues relating to health care financing: the continuing struggle to contain health care costs and the inequitable tax treatment of health care expenditures.

If we learned anything in the health care debate which consumed the last Congress, it is that it is a mistake to act too quickly without fully assessing the practical implications of a legislative proposal. The American health care system is extraordinarily complex. Health care is one-seventh of our economy, a $1 trillion industry which employs millions and, most importantly, provides vital services to every one of us and our families. Any piece of legislation which relates to an industry so large and complex is certain to have dramatic ramifications. Congress saw last year just how disruptive even a well-intentioned proposal could be if not fully considered.

Much of what Congress is seeking to do brings welcome common sense to the subject of health care financing. For example, the permanent extension of the deduction for health insurance expenses of self-employed persons which this Congress passed earlier this year is an excellent first step in making needed health insurance coverage affordable for all our citizens.

With respect to certain other proposals, however, I urge you to heed the lessons of 1994 and take a harder look. In particular, I urge you to consider more fully the practical effects of medical savings accounts, particularly as proposed in H.R. 1818, "The Family Medical Savings and Investment Act of 1995", upon our system of insurance and health care financing.

In general, medical savings accounts, including that proposed in H.R. 1818, would permit persons to make tax-preferred contributions to accounts which could be drawn upon to fund the high deductibles associated with catastrophic health insurance policies. At first glance, the medical savings account has a seductive and emotional appeal. Its concept is simple, and there is an aura of self reliance to it that rings of democracy.

Notwithstanding that initial appeal, however, the impartial experts who have thought through the real world consequences of MSAs, including the Congressional Budget Office, the Congressional Research Service, the National Association of Insurance Commissioners, and the American Academy of Actuaries, have separately concluded that the practical effects of MSAs could be devastating.

It is difficult to overstate the harm MSAs would cause to our current system of health care financing. As the CBO bluntly stated, MSAs "could threaten the existence of standard health insurance."

<u>MSAs Would Undermine Standard Insurance Through Adverse Selection</u>

The CBO concluded that medical savings accounts would "exacerbate the problem of adverse selection" in the health insurance marketplace. By inducing healthier persons to gravitate towards high deductible plans, MSAs would undermine the very purpose of insurance: spreading the financial burden of the few who incur high medical expenses among the many who do not.

If healthy people are given an incentive to take their dollars out of the insurance pool, the results could be disastrous for the older and sicker people who would be forced to pay ever-higher premiums in a futile attempt to insure one another.

That's why the National Association of Insurance Commissioners opposes medical savings accounts, saying "[A]s a result, the health insurance pool would contain a higher proportion of 'high-risk' individuals and insurance costs would be higher for those left in the health insurance pool."

The American Academy of Actuaries reached the same conclusion, stating, "Less healthy individuals who need and select low-deductible insurance plans will likely pay more for their coverage, since the most healthy and highest income persons in the group are likely to select MSA programs." Thus, the Academy of Actuaries observed, "The greatest losses will be for the employees with substantial health care expenditures. Those with higher expenditures are primarily older employees and pregnant women."

Even the Heritage Foundation, a principal supporter of MSAs, has conceded that their appeal is limited largely to the so-called "young immortals" and those in higher income brackets.

Medical savings accounts are presented as an incentive for the health care consumer to shop independently for the best care and the best price. The outdated premise for this argument evolved from a single 1979 Rand Institute Health Insurance Study that implied that if people had to pay more out of pocket for medical care, they would consume less. Significantly, the Rand study predated the introduction of managed care, and could not take into account the gathering momentum of the medical revolution.

Blue Cross & Blue Shield of Ohio concluded a major study two years ago to see if MSAs made sense in a much more evolved medical marketplace. Our study of 38,729 families, a huge sample, demonstrated that MSAs would bankrupt our current system of financing health care and significantly add to the cost of medical care.

The families in the study were insured through Blue Cross & Blue Shield of Ohio's small-business insurance coverage. The total health care charges of the families in the study for one year were a shade more than $159 million, a sum which reflected typical utilization patterns. If MSAs such as those now being considered by the Ways and Means Committee had been in effect, there would have been a shortfall of more than $50 million. That's because the sum of all catastrophic premiums plus all the amounts actually withdrawn from MSAs to pay medical expenses, a much smaller amount than that deposited, would have totalled less than $110 million.

The reason for that shortfall is self-evident. As numerous experts have observed, MSAs would violate the basic tenet of underwriting: that the resources of many are pooled to meet the extraordinary needs of a few. In short, the money that normally would be pooled through the payment of premiums would instead be locked up in MSAs. As a consequence, those funds would be retained in the accounts of the relatively healthy, and would be unavailable for payment of the medical expenses of the relatively sick. The bottom line would be that there would be insufficient funds within the system to cover those who most need medical attention.

This would leave an insurer with one of two options. First, an insurer could increase dramatically the cost of its policies, thus boosting the costs which MSAs are meant to contain. Second, health insurers could exclude the 10% or so of families who incurred the majority of health care costs. If insurers chose that option, MSAs effectively would deprive the most frail, infirm, and chronically ill any health care coverage at all.

Where would those families go for their insurance? Would any private insurer be willing to stop in and provide for such a high risk group? If they did step in and provide insurance, would it be prohibitively priced?

The answer is that those families could not obtain affordable insurance. The result would be that either the government would have to assume the cost of their coverage or those families would be added to the growing number of uninsured Americans.

We don't need to speculate about the harmful effects adverse selection has upon insurance markets and--more importantly--upon the lives and health of the persons who seek to buy insurance. Those effects are evident in insurance markets today.

Right now, the business of insurance is to a large extent an exercise in identifying the healthy people to whom to sell policies and excluding those who actually need the insurance. That is particularly true in the individual market, to which MSAs would be primarily directed.

MSAs would make this unwelcome trend much worse: they are tailor-made for identifying healthy persons who may be profitably insured--it makes no sense for a sick person to utilize an MSA.

Medical Savings Accounts Would Not Effectively Contain Health Care Costs

In addition to causing adverse selection, MSAs would not achieve the individual savings which their advocates claim.

If one accepts the argument that MSAs leads health care consumers to shop for bargains because they would have something to gain, that is, the savings they would retain in their accounts, then one must accept the corollary: consumers will make no effort to limit utilization and contain costs once they exceed a catastrophic deductible because they would have nothing to gain. Those expenses would be borne by the insurer.

Significantly, the great majority of health care costs in our country are incurred beyond typical catastrophic deductibles, costs which would be wholly unaffected by MSAs.

CBO estimates that 83% of health care goods and services are consumed by persons whose medical expenses exceed $2,500 a year. Our study yielded similar data: the healthiest 68% of the families studied consumed only 16% of the health care resources, while the remaining 32% of the families with members who suffered from serious illness spent a stunning 84% of the total. Almost all of the latter amount consisted of health care costs which exceeded catastrophic deductibles.

What's more, MSAs would not even effectively contain costs below catastrophic deductibles. Individual consumers aren't in a position to insist on more productive and efficient medical goods and services. MSAs are based on the inaccurate premise that consumers have sufficient information and expertise to make sound medical purchases. MSAs would provide them with neither.

Reform is induced by informed purchasing by employers and other groups, which MSAs would not promote. Instead, MSAs would weaken the bargaining position of large groups by encouraging healthy individuals to seek health care on their own. If a large employer or other group sought to negotiate only on behalf of the relatively unhealthy, who likely would run up substantial medical expenses, providers would have no reason to offer those groups favorable rates.

Discounts would only be realized by those who effectively sought them out. Moreover, experience proves that providers will offset the cost of discounts by either increasing volume or raising prices to others. Effective cost containment comes from both insurance reform and increased productivity in health care delivery systems, which MSAs would do nothing to promote. While MSAs give individuals incentives to seek discounts, isolated discounts are not synonymous with cost containment and increased productivity.

In fact, MSAs such as that proposed in H.R. 1818 would serve to preserve much of the fee-for-service system which has limited productivity gains, for there is no other practical arrangement for individuals to purchase specific medical services. For that reason, CBO has concluded, "[T]he catastrophic-plus-MSA option might attract people out of group- and staff-model health maintenance organizations. Those people would no longer benefit from the efficiencies of HMOs." Because H.R. 1818 expressly limits MSAs to persons covered by catastrophic policies, it would drive consumers away from the low- or no-deductible managed care plans which have proven in the medical marketplace as among the most effective means of containing health care costs.

In addition, MSAs would blunt the financial incentives which would otherwise encourage consumers and providers to restrict themselves to medically necessary and appropriate services. Advocates of MSAs regularly have taken out ads which claim that the accounts are a means of funding health care without government involvement. The opposite is true. H.R. 1818, like all MSA proposals, provides that consumers would not bear full cost of medical expenses funded by MSAs--those expenses would be subsidized through the tax system. Under present law, consumers bear the full cost of deductibles up to 7.5% of adjusted gross income. Thus, MSAs would eliminate certain disincentives to over-utilize health care.

Finally, MSAs such as that proposed by H.R. 1818 would impede effective cost containment because they generally may be drawn upon to be spent tax free on any "medical expenses," a term which includes a great many health care costs which cannot be applied to a catastrophic deductible. Thus, MSAs would provide a tax subsidy to many expenses presently borne fully by the consumer, thus encouraging additional consumption.

MSAs Would Discourage the Use of Primary and Preventive Care

H.R. 1818, like other MSA proposals, would discourage the use of primary and preventive care. Specifically, MSAs seek to reduce demand for care without reducing the need for care through health prevention and promotion efforts.

MSAs would discourage the use of cost-effective primary and preventive care because those expenses likely would not be covered by insurance. On the other hand, the consequences of the failure to obtain such care would be fully covered once the catastrophic threshold was crossed.

MSAs impose a financial penalty upon persons who seek primary and preventive care. Because, as MSA advocates stress, the accounts are personal property, withdrawals from the accounts take money out of the pockets of the patients. The resulting disincentive to seek primary and preventive care would be avoided through the use of a standard low-deductible policy.

This problem may be mitigated in part if a portion of the amounts deposited in MSAs were forfeited unless spent on preventive care, but H.R. 1818 has no such provision.

Medical Savings Accounts Would Constitute Regressive Tax Policy

H.R. 1818, like most MSA proposals, provides that contributions to MSAs would be tax deductible. Because tax deductions are worth more to high income taxpayers who are subject to higher marginal rates, MSAs would be highly regressive.

What's more, MSAs would be utilized disproportionately by high income persons because low to moderate income individuals often lack sufficient liquidity to establish MSAs.

On the other hand, MSAs would hurt the poor and the sick. MSAs, by design, require dramatically increased cost-sharing by consumers. Yet studies show that increased cost-sharing adversely affects health outcomes for persons with unhealthy life styles, a group which is disproportionately poor.

In the end, medical savings accounts would serve only the healthy, and only the wealthy could afford healthy insurance.

How to Contain Health Care Costs

If medical savings accounts are not the answer, how do we contain health care costs?

The debate over the issue of health costs takes many forms and directions, bringing with it an increasingly emotional dialogue that, for the most part, overlooks the fact we are in the midst of a medical revolution as great in magnitude as was the Industrial Revolution. It is important to understand this when we address the issue of health care costs, for it is not like debating another trade agreement, public works project, or entitlement program.

We must deal with the growing expense of medical care, but we must understand that a substantial part of the cost is a dual health care system, one encumbered by the past with a vast network of hospitals no longer needed, but costing more and more to maintain.

This health care system represents Parkinson's Law at work -- over time, the structure of our medical community has expanded without any direct relation to the nature of services or delivery system required to meet efficiently the public's needs.

The second system we are supporting is in the vanguard of the medical revolution: the technologically advanced, research oriented, vertically integrated delivery systems, and more sophisticated concepts of managed care. This system is designed to provide ambulatory outpatient care for more than 80% of those services previously provided on an inpatient basis.

America cannot afford to support two health care systems. In the debate over health care cost containment, too little consideration has been given to this reality. Instead, health care reform proposals have tended to focus on how to pay to maintain what is already in place.

Rather than concentrate on new ways to fund our wasteful dual system, we need to search harder for ways to save money.

One in three hospital beds goes unused in this nation. We need to close more hospitals and work to build a vertically integrated system that brings doctors, hospitals, and insurers together as a team to manage costs. This must be done to combat excess capacity and duplication of high technology that hospitals use to compete with each other.

Cost management will become more critical as the medical revolution gains in momentum and offers medical advances that promise to abate cancer, fight heart disease, and prolong life. The unlocking of genetic codes will change medicine forever. Unless we deal with the realities of today, the medical triumphs of tomorrow will be available only for the privileged.

We recognized the need to address the future in 1987 when we urged passage of an Ohio law that enabled Blue Cross & Blue Shield of Ohio to negotiate for the best hospital rates for its 1.5 million customers.

This action helped Cleveland drop from the fourth most expensive hospital city in the U.S. to the 33rd in nine years. By projecting the "Cleveland Model" nationwide, an annual savings of $20 billion could be achieved, enough to cover nearly 12 million uninsured Americans.

In addition, Blue Cross & Blue Shield of Ohio joined with the Greater Cleveland Growth Association (Cleveland's chamber of commerce) and the Council of Smaller Enterprises to create an alliance which led to the nation's biggest small group purchasing coalition for health care. This prototype has been the subject of study by other groups across the country.

Blue Cross & Blue Shield of Ohio has also taken the lead in containing health care costs by fighting systemic waste and fraud. Experts estimate that 25% of the cost of the U.S. health care system is lost through waste and fraud. That is nearly $230 billion annually. Even a partial list of potential savings shows the significance of the problem:

- $4 billion annually if uniform claim forms and electronic claims processing and billing could be put on line nationally, according to the U.S. Department of Health and Human Services.

- $20 billion through the reduction of unnecessary patient care and other administrative savings through computerized patient records, as estimated by the U.S. General Accounting Office and the Department of Health and Human Services.

- $80 billion by the elimination of health care fraud, estimated at upward of 10 percent of total medical expenditures by the U.S. General Accounting Office. In Cleveland alone, a special fraud squad set up by Blue Cross & Blue Shield of Ohio has saved an average of $2 million a year.

- $42 billion that is attributed by the American Medical Association to the treatment that results from unhealthy habits such as smoking, drinking, obesity, and violence.

- $10 billion that is lost to the insurance system by the 12 million Americans who choose not to take available health insurance and make the rest of us pay more for coverage.

- $6 billion in excessive drugmaker profits and research and development of "me too" drugs that represent no therapeutic gain, according to the U.S. Office of Technology Assessment and the House Energy and Commerce Committee.

- $19 billion of excess costs from the 11% of physician procedures deemed unnecessary or inappropriate, as estimated by the Value Health Sciences, Blue Cross & Blue Shield Association, and U.S. Health Care Financing Administration.

When you consider that these sums far exceed the estimated cost of covering the nations's uninsured, you get some idea of what could be done with these wasted dollars. My point is that there is much we can do to streamline the health care system without adding more money to it.

Conclusion

MSAs proponents ask the right question--how can staggering health care costs be contained? But MSAs are the wrong answer.

In essence, MSAs would require taxpayers to provide a first-dollar subsidy for costs that individuals can bear themselves. Moreover, that subsidy--by design--would be higher for the affluent than for persons of limited means.

In return for that subsidy, taxpayers would get nothing but the bill. Health care costs would not be reduced. To the extent costs would be affected at all, they would be shifted rather than contained. Moreover, MSAs would have no impact on the great majority of health care costs which are incurred beyond catastrophic deductibles.

The worst aspect of MSAs, however, would not be their expense or their failure to contain costs. The greatest flaw of MSAs would be their devastating impact on insurance markets.

By inducing healthier persons to gravitate towards high deductible plans, MSAs would undermine the very purpose of insurance–spreading the financial burden of the few who incur high medical expenses among the many who do not. The CBO got it right--MSAs "could threaten the existence of standard health insurance."

Health care reform is an extremely complex undertaking for which there are no simple answers. If something sounds too good to be true, it usually isn't. And nothing sounds better than the premise of MSAs–that we can contain health care costs by creating a vast new tax break. Unfortunately, it just isn't so.

Health care costs can be contained, but not through the gimmickry of medical savings accounts. I look forward to working with Congress and the Ways and Means Committee to identify and implement the steps necessary to secure a sound financial basis for our nation's health care system.

Statement by Greg Scandlen, Executive Director
Council for Affordable Health Insurance

Mr. Chairman, my name is Greg Scandlen and I am Executive Director of the Council for Affordable Health Insurance. The Council, also known as CAHI, is an association of small to mid-sized insurance companies that was formed in March 1992 to fight for free market solutions to the problems in the health care system. We also represent several hundred individual members including some of the nation's leading actuaries, physicians, insurance agents and Americans interested in free market solutions to the nation's health care problems.

Mr. Chairman, I would like to take this opportunity to thank you for conducting these hearings on H.R. 1818, the Family Medical Savings and Investment Act of 1995. I would also like to thank Chairman Bill Archer and your colleague, the Honorable Andy Jacobs of Indiana for their dedication to the issue of free market health care reform through the enactment of federal medical savings account legislation.

As I am sure you are all aware, Mr. Archer and Mr. Jacobs introduced legislation similar to H.R. 1818 in the 102nd U.S. Congress and in the 103rd U.S. Congress. Those bills, too, attracted a broad spectrum of Democratic and Republican co-sponsors. However, H.R. 1818 has become the definitive medical savings account bill in the 104th U.S. Congress because it accomplishes so much with little or no cost to the federal government.

The MSA concept is a popular one both in this Congress and in the state legislatures. Since the Council was founded in 1992, 13 states have enacted medical savings account laws including Arizona, Colorado, Idaho, Illinois, Indiana, Michigan, Mississippi, Missouri, Montana, New Mexico, Oklahoma, Utah, and West Virginia. Two additional states, Washington and Virginia, have recently enacted MSA laws that rely on further federal action to make them marketable. Medical savings account legislation is also pending in an additional 16 states. While the states have certainly taken the lead in developing innovative insurance reforms in the past, medical savings accounts have taken the lead in the states in 1995.

As the Executive Director of CAHI, I am also an employer with seven employees, and each of us is using a medical savings account system to keep down the cost of our individual health care. By moving from a low deductible policy to a high deductible policy, we have saved enough money to fund our $1,000 deductibles. However, we must pay state and federal taxes on this additional money because under current tax laws, this $1,000 is a taxable benefit. Why should my employees be penalized by the U.S. Tax Code for being prudent purchasers of health care?

H.R. 1818 begins to address the problem of federal tax inequity for individuals and the self-employed who must purchase their own health coverage. It does so by allowing these individuals to deduct their MSA contribution, even though they might not be able to deduct the cost of the catastrophic insurance plan. None the less, the MSA deduction is a substantial step in the right direction.

H.R.1818 also provides a source of funds for preventive care, and gives incentives to begin saving for health care when it is really needed, and really expensive, later in our lives. Many employees with regular deductibles or copayments do not have sufficient out-of-pocket funds to access preventive care services. MSAs provide a source of funds to pay for these services, even for low income workers.

H.R. 1818 also allows long-term care insurance premiums to be considered a qualified medical expense under the U.S. Tax Code, and it allows LTC insurance premiums to be paid directly from the MSA. By promoting the purchase of long-term care insurance, H.R. 1818 will, in the long run, help reduce Medicaid costs.

Medical savings accounts, as designed under H.R. 1818, will also make a major contribution to reducing the numbers of uninsured in this country, and lessening the problem of "job-lock." It will do this by providing employees with a source of funds to pay for COBRA continuation coverage when they are between jobs. As you know, most of the uninsured are without coverage only for a short period of time, usually when they have lost their job. This is the very time when they are least able to afford to pay for health insurance because they are without an income. MSAs directly address this very real problem.

Many have referred to medical savings accounts as a cousin of the Section 125 flexible spending account (FSA). H.R. 1818 brings these two closer together by allowing an employee to make an annual contribution from an FSA into an MSA. By addressing FSAs in their legislation, Chairman Archer and Rep. Jacobs have responded to the concerns raised by employers about the uncertainty that has existed about Section 125. Section 125 remains a popular element of health care reform that many rely on not only for health care, but for other cafeteria-type plans and services. CAHI believes that Section 125 will be enhanced by H.R. 1818, and will not and should not, be jeopardized by Medical Savings Accounts.

During the past three years, several dozen versions of medical savings accounts have been introduced in the U.S. Congress. Until the dawn of the 104th Congress, most of the beltway interest groups did not pay much attention to the concept, but in recent months, my organization has been flooded by requests from hundreds of organizations trying to get up-to-speed on the issue. We have been working overtime to educate these interest groups, but I'm afraid there are still some misconceptions out there.

The biggest concern we hear is that Medical Savings Accounts may lead to adverse selection, meaning that only the young and healthy would want an MSA, leaving the sick and aged behind in HMOs and other managed care settings. This concern must be clearly addressed and understood because it is so misleading, and possibly self-serving.

There are a few things we know about selection. One of them is that high users of health care services avoid managed care whenever they can. Why? Because their one great priority is to preserve their personal network of providers. Many observers attribute all of managed care savings to this very process -- the young and healthy don't mind going into an HMO, because they don't have ties to any particular physician. Therefore the average cost of an HMO is lower. Foster Higgins surveyed nearly 1,000 mid-sized firms and discovered that in dual choice situations, the indemnity plan was $1,000 more expensive per employee than the HMO alternative because, "healthier employees choose the HMO, and the indemnity plan is left with the poorer risks." (*Highlights*, September, 1994) To the extent MSAs help preserve their choice of provider, MSAs will be extremely attractive to high risk individuals.

But that is just half the reason they would opt for an MSA. Under most traditional indemnity plans, including fee-for-service PPOs, the insured is responsible for paying a regular deductible and a substantial copayment, totaling thousands of dollars. In most MSA arrangements we have seen, the high user of services will actually have to pay less out of pocket than they do today, provided of course, that the tax advantages of the Archer/Jacobs bill are available.

Because many state mandated benefits require first dollar coverage of certain services, the catastrophic policy as defined in H.R.1818 would be illegal in those states. There are two ways to address this problem, either of which would be acceptable to my organization:

1. Include a federal preemption of state benefit requirements for these catastrophic insurance plans;

2. Include these state benefit requirements in the definition of "permitted coverage," thereby allowing the catastrophic policy to provide coverage for those state mandates.

Mr. Chairman, you have before your committee today health reform legislation that will accomplish more than any other health reform plan I have seen. At little or no cost to the federal government, H.R. 1818 will return our health care system to individuals by allowing them their choice of physicians, facilities and services; it will allow them to save for their long-term care and to pay for services not covered by their insurance; it will stabilize and reduce the spiraling cost of health insurance by dramatically reducing administrative costs; it will avoid adverse selection; it will strengthen the doctor-patient relationship; but more importantly to the House Committee on Ways & Means, it will save the federal government precious dollars in the long run by reducing health care costs without artificial controls, price caps, or a new and potentially costly bureaucracy.

Our current health care system is not broken, but it has been badly harmed by over-regulation, tax inequities, and incentives to spend money rather than save. H.R. 1818, the Family Medical Savings and Investment Act of 1995, will not solve all our nation's health care problems, but it will certainly go a long way in providing choice and quality of care to all Americans, giving them proper incentives to stay healthy, get preventive care, and save for the future. H.R. 1818 is an American solution to an American problem and should be enacted. Thank you, Mr. Chairman.

STATEMENT OF THE GROUP HEALTH ASSOCIATION OF AMERICA

This testimony is submitted for the hearing record by the Group Health Association of America (GHAA), the leading national association for health maintenance organizations (HMOs). GHAA's 385 member HMOs serve 80 percent of the 50 million Americans who receive health care from HMOs. Our member plans started -- and continue to lead -- the nation's move to high quality, organized health care delivery.

The Group Health Association of America (GHAA) appreciates the opportunity to submit this statement for the record to discuss the Chairman's "Family Medical Savings and Investment Act of 1995" as well as other proposals that establish tax-preferred medical savings accounts (MSAs). GHAA supports the need for expanded choice of coverage options in the health care marketplace. However, as Congress works towards this goal, it is important that all options be treated in an equitable manner, both in terms of tax and regulatory treatment.

GHAA applauds Chairman Bill Archer and Representative Andrew Jacobs' interest in providing consumers with an additional option for their health care benefits coverage and in encouraging individuals to become more educated and prudent consumers of health care services. However, we have concerns with certain features of the H.R. 1818, specifically the mandatory linkage with catastrophic coverage, the unlimited accumulation of unused tax-preferred MSA funds, and the ability to use MSA funds for non-health related expenses.

Our concerns with elements of H.R. 1818, as well as with other proposals that link MSAs with catastrophic coverage, are focused on the competitive advantage that these proposals grant to catastrophic coverage over other forms of comprehensive coverage, including HMOs. By restricting access to MSAs, individuals who might otherwise select HMO coverage may be encouraged to purchase catastrophic coverage, losing the benefits of HMO-based care delivery. In many ways, HMOs' philosophy is fundamentally at odds with catastrophic coverage, and thus, with proposals that link MSAs with catastrophic coverage.

HMOs believe that the availability of preventive care and early treatment for health problems promotes better health and is more cost-effective than traditional fee-for-service coverage. In addition, HMOs treat health problems in a comprehensive, coordinated fashion to ensure that patients receive the most appropriate care in the most appropriate setting. The indemnity-based catastrophic coverage that is likely to be available under an MSA/catastrophic coverage option provides a fragmented, uncoordinated approach. This lack of coordination and continuity imposes unnecessary costs and exposes patients to unnecessary risks.

H.R. 1818: "The Family Medical Savings and Investment Act of 1995"

H.R. 1818 would allow eligible individuals to establish a tax-preferred "medical savings account" (MSA) if they have health insurance coverage through a catastrophic plan. Catastrophic coverage is defined as a health plan that provides coverage for health services after the enrollee has met a minimum deductible of $1,800 for individuals or $3,600 for families. Individuals who receive catastrophic coverage from their employer would be able to deduct the amount that either their employer or they had contributed to their MSA during the plan year, up to the lesser of the catastrophic plan's deductible or $2,500 ($5,000 for families). Self-employed individuals and individuals without employer-provided coverage could deduct contributions to their MSA, but could not use money in their MSA to pay for their catastrophic plan premiums (such payments would be treated as they are under current tax law, self-employed individuals could deduct 30 percent of their premiums and individuals could deduct premiums to the extent that they exceed 7.5 percent of their adjusted gross income).

MSA participants could not use their MSA funds to purchase health benefits coverage (including catastrophic coverage), except for long-term care coverage. Withdrawals from an MSA would

be excluded from income if used for qualified medical expenses (as defined under IRC §213*). Withdrawals for non-health related expenses would be permitted, but would be treated as taxable income and assessed a 10 percent penalty.

Concerns with MSA/Catastrophic Coverage Proposals

As stated above, GHAA is concerned with the structure of H.R. 1818's MSA proposal because it links MSA availability to an indemnity-type catastrophic plan and thus, provides more favorable tax treatment to a specific form of coverage than other health care coverage options. We believe that this catastrophic-based structure is likely to have a negative impact on the current health care marketplace as well as on consumers -- those who remain enrolled in a comprehensive coverage arrangement, such as an HMO, who likely will face increasing premiums, and those with MSA/catastrophic coverage option who likely will find themselves "at-risk" for a significant portion of their health care costs.

GHAA believes that MSA/catastrophic coverage designs are problematic for the following reasons:

- ***Interferes with market dynamics***. Under current tax law, all employer-based health benefits coverages (excluding coverage provided to the self-employed) receive the same tax treatment -- whether an employee selects HMO, PPO, FFS or catastrophic coverage. Under H.R. 1818, individuals with employer-provided catastrophic coverage would receive the additional benefit of being able to (or having their employer) set aside tax-preferred dollars an MSA to cover unreimbursed health care expenses. GHAA believes that the favorable tax treatment of employees' out-of-pocket payments for health-related services under MSA/catastrophic coverage gives a financial incentive to select MSA/catastrophic coverage in preference to comprehensive coverage, such as HMOs. Providing a tax advantage to catastrophic coverage could undermine the positive trends that HMOs are creating in the marketplace by serving to lower the growth of health care costs and improve quality of care. By assigning MSA/catastrophic coverage options tax advantages over other coverage options, the federal government is essentially picking "market winners" and encouraging employers and employees to choose MSAs for their tax benefits instead of evaluating their overall quality and cost-effectiveness.

- ***Creates adverse selection against comprehensive coverages***. Experience with flexible spending arrangements and catastrophic products has shown that catastrophic coverage -- which has lower premiums because of the significant deductible -- tends to be most attractive to young, healthy individuals who have no or limited expectations for requiring health services. Conversely, older and less healthy individuals will be unlikely to find catastrophic coverage attractive, given their anticipated need for health care services. As a result, tax-preferred catastrophic coverage likely would result in adverse selection against HMO and more comprehensive coverage options, thereby increasing premium costs for those remaining in the comprehensive coverage arrangements.

  The likelihood for adverse selection was highlighted by the National Association of Insurance Commissioners (NAIC) in the context of last year's reform debate. In a letter to the Senate Leadership, NAIC's Special Committee on Health Care Reform expressed their concern that individuals at low risk for expensive health care treatment would opt for catastrophic coverage, leaving the non-catastrophic health insurance pools with a high proportion of "high risk" individuals and causing insurance costs to be higher for those left in the health insurance pool.

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*Limited deduction allowed for unreimbursed expenses for "medical care," including amounts paid for the "diagnosis, cure, mitigation, treatment, or prevention of disease;" for transportation "primarily for and essential to such medical care;" and for "insurance covering such care." Deductions are not allowed for cosmetic surgery unless it is deemed necessary.

The current health care marketplace has evolved to limit selection bias and to ensure that various coverage options serve similar populations. Contrary to statements that have been made about selection patterns in HMOs, evidence is accumulating that HMOs care for unhealthy and chronically ill populations at approximately the same rate as the fee-for-service (FFS) sector. A study published recently in the peer-reviewed journal *Health Affairs* ("Do HMOs Care For the Chronically Ill?", *Health Affairs,* Spring 1995) noted that there is no consistent pattern to the types of individuals with chronic conditions that are enrolled in HMO or FFS plans. An analysis by the National Research Corporation found similar results, concluding that the self-assessed health status of the HMO and FFS populations is virtually identical.

- ***Leaves individuals with considerable exposure for out-of-pocket costs.*** MSA/catastrophic coverage proposals that rely on employer funding for MSAs with money saved from switching from "comprehensive" coverage plans to catastrophic-type plans could leave individuals with considerable out-of-pocket expenses. According to analyses by the Congressional Research Service (CRS) (using the Hay Group) and Ford Motor Company, annual employer contributions to MSAs are likely to be significantly lower than the catastrophic plan's deductible, requiring individuals to pay for the majority of their care on an out-of-pocket basis. For example, catastrophic coverage with a $2,500 deductible would reduce premiums by only about $600 for individual coverage over a typical comprehensive coverage alternative. Assuming that the employer puts all of the "savings" in the employee's MSA, it would take over four years for the employee to accumulate enough funds to cover the deducible, assuming that the individual does not withdraw any money to pay for medical expenses.

Recommendations for Modifying H.R. 1818

To ensure that MSA proposals do not provide a competitive advantage to catastrophic coverage and to maintain a level playing field among all types of health benefits coverage offered within the employer-based health care system, we recommend that MSA proposals be modified by incorporating the following elements:

- ***Eliminate the catastrophic coverage link.*** Allow an MSA option to be offered to any eligible employee, whether they receive health benefits coverage through a catastrophic coverage or a comprehensive coverage option, such as an HMO. MSAs should be available to all eligible employees regardless of the type of coverage they select in order to promote choice among coverage options based on quality and cost-effectiveness.

- ***Ensure that MSAs do not receive inequitable tax treatment,*** by limiting the amount of funds that could be maintained in an individual's MSA in a given year and by allowing MSA withdrawals only for health-related expenses. Limiting MSA balances (contributions and accumulations) to a set amount would limit MSAs savings potential and therefore, limit the perception of MSAs as a non-health care related savings account. Individuals currently have access to individual retirement accounts (IRAs) which are designed explicitly as a vehicle for long-term savings and will serve the purposes of long-term savings more effectively than MSAs.

  Limiting MSA withdrawals to health-related expenses also would minimize the chance that individuals would use their MSAs for purposes other than health benefits coverage (e.g., savings for future non-health related purchases or as a tax shelter). Allowing MSA participants to use unspent MSA funds on non-health related expenses, even with strict penalties, provides an incentive to avoid obtaining preventive and/or routine health care services in order to build up balances to pay for cars, homes, etc.

- ***Establish strict rules for switching between catastrophic and comprehensive coverage.*** Require employees to indicate their intent to switch from catastrophic to comprehensive coverage at least one year before the start of the new plan year. Requiring MSA participants to wait a year before switching to comprehensive coverage would protect

HMOs and other comprehensive coverage plans from adverse risk selection by limiting employees' abilities to select catastrophic coverage during healthy years and switch to comprehensive coverage when specific health conditions emerge.

- ***Require catastrophic coverage policies to meet the same standards as other health benefit plans.*** Catastrophic coverage should be subject to the same standards that apply to other health plans, to ensure that individuals have the same access to all coverage options. For example, catastrophic coverage would have to be offered on a guaranteed issue basis (i.e., without regard to health status) if federal of state law includes such a requirement for other health plans.

GHAA believes strongly that consumers should have a choice among a wide variety of coverage options in the health care marketplace. However, to build on the advances that health plans have made in recent years to provide high quality, cost effective care to their enrollees, it is crucial that reform proposals -- particularly those proposals that establish tax-preferred MSAs -- treat all plans in an equitable manner. The catastrophic coverage-based MSA provisions described in H.R. 1818 could reverse advances in the current marketplace, by providing a tax advantage to old-style, uncoordinated, and inefficient health care coverage. To this end, the federal government should not provide catastrophic plans more favorable tax treatment than comprehensive coverage options by linking MSA availability with a catastrophic coverage requirement.

As this MSA legislation moves forward, we urge you to consider the serious consequences that could result for the health care marketplace and for consumers if MSA proposals are not designed in a thoughtful manner.

Virginia Bankers Association

BENEFITS CORPORATION

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July 5, 1995

Mr. Phillip D. Mosley
Chief of Staff
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Re: Statement for the Record for the June 27, 1995 hearing on HR 1818 Family Medical Savings and Investment Act

Dear Mr. Mosley:

I am John Vellines, Chief Administrative Officer of the Virginia Bankers Association Benefits Corporation. I am submitting this testimony not as a banker, but as an administrator of a trade association sponsored multiple employer health insurance trust. The Virginia Bankers Association has been offering health insurance to its members for 49 years, and 78% of the banks participate in our plan.

The Virginia Bankers Association Benefits Corporation wholeheartedly supports the concept of Medical Savings Accounts, and specifically endorses HR 1818. We believe that one of the reasons that medical care costs have consistently risen faster than inflation in general is that the receiver of the medical service is not the direct payer of that service. While not a total solution to that problem, MSA's will assist in bringing the patient into the loop as a better consumer.

We would like to respectively suggest that the committee consider several changes to the bill that we believe will counter some of the objections of the MSA concept and make the bill more effective.

1. To assure that MSA participants do not ignore preventative care, we suggest that the redesignated Section 220 (c)(3) Permitted Coverage be extended to allow a panel of adult preventative care treatments, as well as well baby care and immunizations for infants. The Preventative panel can provide for a schedule of treatments, such as mammograms, pap smears, and PSA tests based on age and sex.

   One efficient way to provide this coverage is to allow the catastrophic policy to pay first dollar coverage for preventative and well baby care subject to a modest co-pay, such as $15. This would encourage adults to get the preventative care they need, and assure that parents will not be disincented to provide for the important medical care needs of their infants.

   This method of covering preventative care would only add about 2% to the price of the $1,800 catastrophic insurance policy.

2. We suggest that retirement be added to the list of permitted tax free withdrawals, subject to existing IRA withdrawal rules. While this recommendation seems to vary from the "pure" intent of MSA's, we believe that encouragement of retirement savings is a very high societal priority, and we should take advantage of this perfect opportunity to blend the two goals. Adding this feature will make MSA's more attractive to a broader segment of the population, and ultimately relieve some of the long term pressure on the Social Security Retirement system.

Your staff will have to determine the budgetary ramifications of this change, but we suspect that the short term effect would be minimal. Society's long term benefit should offset any short term budgetary impact.

3. Much of the debate centers over the inability of MSA's to take advantage of the gains that Managed Care have brought to the table over the last few years. We believe that it may be possible to merge the two concepts. Initially, we would recommend a Preferred Provider Organization (PPO) network overlay. This would at least allow MSA participants to take advantage of existing physician and hospital contracts and discounts. Further extensions into gatekeepers, etc, will evolve over time.

   While it would appear that HR 1818's silence on this issue would allow MSA administrators to proceed with Managed Care initiatives on their own, you may wish to insert language encouraging these efforts.

In summary, let me repeat our strong support for this bill. We believe that this first step will go a long way in solving one of the core problems in America's health care system.

Sincerely,

John B. Vellines
Chief Administrative Officer

JBV/bhc

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